Minds That Matter

Report on the consultation on human rights, mental health and addictions

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Human Rights Commission
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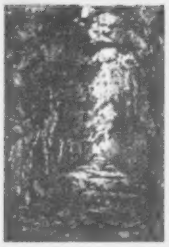
About the artists...

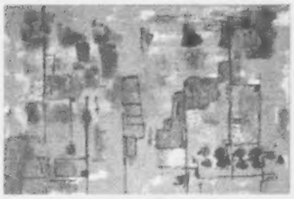
The artwork in this book was created by members of Workman Arts. This arts and mental health company is known internationally for its artistic collaborations, presentations, knowledge exchange, best practices, and research in the area of the impact of the arts on the quality of life of people living with mental illness and addiction.

Workman Arts (WA) facilitates aspiring, emerging and established artists with mental illness and addiction issues to develop and refine their art form through its arts training programs, public performance/exhibit opportunities and partnering with other art organizations. As well, WA promotes a greater public understanding of mental illness and addiction through creating, presenting and discussing artistic media.



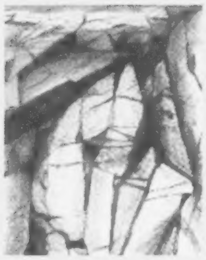
Emily Eng – I Have Seen a Road

Emily Eng is a printmaker, sculptor, painter and educator who lives and works in Toronto. She tries to expose universal sufferings we all endure and inflict on others and ourselves. Her works have been exhibited in Italy, Korea and Canada and are included in private, corporate and institutional collections.



Laveh – Boxed in

Lindsay Veh studied at the Ontario College of Art and Design (OCAD). She lived and worked in the USA and Europe for some time, returning home to Toronto, to continue her creative endeavours as a full-time visual artist, art facilitator and actor. Lindsay works in acrylics, watercolour, pen and ink and mixed media, painting abstract and abstract/figurative works, as she is fascinated by people's body language, emotions and often paints them into abstract surroundings. www.artbylaveh.com



Pavel Janacek – Unreachable is Ideal

Pavel Janacek is a Czech-born artist who immigrated to Canada in 1969. He was educated at the Ontario College of Art and Design (OCAD) and has been an artist for over 30 years. He works in oil on canvas, depicting mainly landscapes. His work is held in private and institutional collections and has been exhibited in Minnesota and throughout Toronto.

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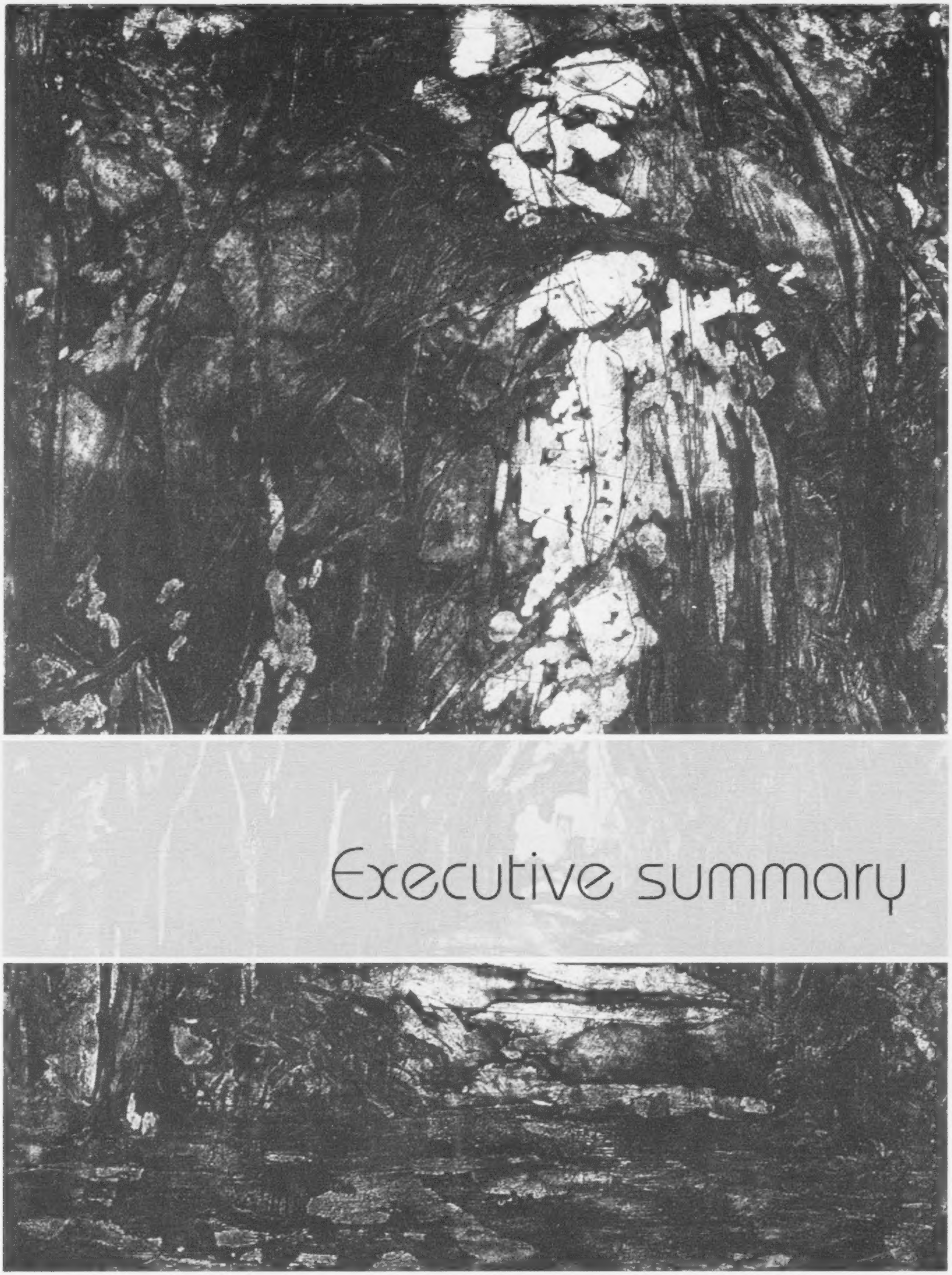


Executive summary

Executive summary

Minds that Matter reports the findings from the Ontario Human Rights Commission's (OHRC) province-wide consultation on the human rights issues experienced by people with mental health disabilities or addictions. It provides a summary of what we heard from more than 1,500 individuals and organizations across Ontario.

Throughout the consultation, we heard significant concerns about the discrimination and harassment facing people with mental health disabilities or addictions in many aspects of their lives. Mental health disabilities can include schizophrenia, bipolar disorder, depression and anxiety disorders. Addictions can include alcohol and substance addictions and problem gambling.

We heard that people with mental health issues or addictions face common stereotypes – that they are a security risk or are incapable of making decisions for themselves. These stereotypes result in widespread discrimination in housing, employment and services, and are deeply embedded in legislation, institutional policies and practices of institutions and individual attitudes.

Many people with mental health issues or addictions don't know they have a legal right to be free from discrimination under the Ontario *Human Rights Code* (the *Code*). In addition, we heard how rules, policies and practices in employment, housing and services are not designed with the needs of people with mental health issues or addictions in mind. Multiple barriers are created that prevent people from accessing these areas equitably. For example, services may not be designed to include people with episodic disabilities; people may be told they have to meet the criteria for being considered permanently disabled to be eligible for a service.

Many organizations do not appear to be aware of their responsibilities under the *Code* to uphold the human rights of people with mental health disabilities or addictions. We were told that many organizations need guidance on how to meet their duty to accommodate the individual needs of people with mental health or addiction disabilities. Also, where these rights conflict, we heard that balancing the rights of people with mental health or addiction disabilities with the rights or needs of others can be challenging.

Important themes that ran throughout the consultation were respect for people's dignity, privacy and individual differences, as well as people's rights to autonomy, non-discrimination, and full integration and participation in the community. These principles are grounded in the United Nations' *Convention on the Rights of Persons with Disabilities (CRPD)* and mirror the purpose of the *Code*. For example, many people raised privacy concerns, telling us that their disability-related information was inappropriately requested or shared by employers, housing or service providers.

We heard how societal factors create the conditions for discrimination and exclusion of people with mental health issues or addictions. Poverty was a clear theme in people's lives. In Ontario, people with mental health issues or addictions are much more likely to live in poverty than people with other types of disabilities or without disabilities. We heard that barriers to housing, services and employment opportunities for people who have low income will likely disadvantage people with mental health issues or addictions.

As well, we were told that a shortage of affordable housing opportunities and high levels of poverty often result in homelessness. The lack of available mental health services, housing and other supports has resulted in too many people with mental health issues and addictions in the criminal justice system. Discrimination contributes to low levels of education and high levels of unemployment and poverty.

We also heard that discrimination based on other disabilities and other *Code* grounds affect people's mental health and well-being. Other grounds cited included:

- Race and related grounds, including Aboriginal identity
- Age
- Sex and gender identity
- Sexual orientation.

Discrimination based on mental health and addictions can combine or intersect with other forms of discrimination, creating distinct experiences of disadvantage. People with addictions may face unique forms of stereotyping and inequities compared to people with only mental health disabilities.

Some forms of discrimination are explicit and direct; others unintentional and subtle. Some rental housing providers, employers and service providers, including health care providers, may turn people away based on disability-related factors. Stereotyping can lead to harassment towards people with disabilities in the form of negative comments, social isolation and unwanted conduct from employers, landlords, co-workers or service providers. We also learned how people can be denied employment, service or housing opportunities because seemingly neutral rules actually lead to disadvantage; these can include tenant screening practices, hiring practices or police background checks.

There are signs that a shift is underway in how people with mental health issues or addictions are viewed. Mental health has been made a government priority at the provincial and federal levels. The U.N. *Convention on the Rights of Persons with Disabilities* changes the focus on persons with disabilities from recipients of charity to holders of rights. By ratifying this convention, Canada has agreed to take steps to ensure equality and non-discrimination in many aspects of life for all people with disabilities. Across Ontario, there is increasing awareness and acknowledgment of the major barriers that people with mental health issues and addictions face. Individuals and organizations are asking for more education about mental health, and for changes to laws and policies to end negative stereotyping and discrimination.

Preventing and eliminating discrimination is a shared responsibility. This report sets out recommendations for action for government, housing providers, employers, service providers and other parties, as well as a series of OHRC commitments towards eliminating discrimination based on mental health and addictions in Ontario.

PART A:

Background and context

1. Introduction

> Being a mental health patient seems to give people the right to do whatever they wish to you because you will not be seen as a valued member of our society. My mental health issues should not define me as an individual.
>
> – Written submission

In Canada and internationally, we have seen major advancements in human rights protection for people with disabilities. But in our consultation on human rights, mental health and addictions in Ontario, we heard a different story.

We were told that people with mental health disabilities and addictions continue to experience significant marginalization and exclusion. We heard that even though people are protected from discrimination and harassment under the Ontario *Human Rights Code (Code)* based on the ground of "disability," this is often not the lived reality.

In 2009, the OHRC identified mental health as a "strategic priority." This report is the result of a province-wide consultation on the human rights issues facing people with mental health disabilities and addictions. The goal was to identify factors that undermine the opportunities for people with mental health disabilities and addictions to fully take part in the economic, social and cultural life in Ontario. The consultation will inform our future work, and will set the stage for an OHRC policy on human rights and mental health. The OHRC's policies reflect our interpretation of the *Code*, and set out standards, guidelines and best practice examples for how individuals, service providers, housing providers, employers and others should act to ensure equality for all Ontarians.

The Ontario Human Rights Commission is an independent statutory body whose mission is to promote, protect and advance human rights across the province as set out in the Ontario *Human Rights Code* (the *Code*). To do this, the OHRC identifies and monitors systemic human rights trends, develops policies, provides public education, does research, conducts public interest inquiries, and uses its legal powers to pursue human rights remedies that are in the public interest.

This report documents feedback from participants on how people may experience barriers such as direct discrimination, harassment, lack of accommodation, or systemic discrimination that may violate their rights under the *Code*. It will also show that many factors in society create the conditions for discrimination. People's experiences may be linked to human rights that are protected under the *Canadian Charter of Rights and Freedoms (Charter)*, or in international human rights instruments, such as the United Nations' *Convention on the Rights of Persons with Disabilities (CRPD)*.

Hundreds of individuals and organizations identified many different types of inequalities and concerns that lead to widespread discrimination against people with mental health issues and addictions. Some organizations found it difficult to understand and fulfill the obligations under the *Code*. They said this was particularly the case when interpreting the duty to accommodate people with mental health and addiction disabilities to the point of undue hardship – especially in complex situations where some people's human rights may compete with the rights of others. As with other *Code*-protected groups, we recognize that addressing human rights concerns facing people with psychosocial disabilities can sometimes be challenging for all parties involved; each party's perspective needs careful consideration.

Removing discriminatory barriers and ensuring equity for people with mental health issues and addictions is a shared responsibility. Concerted effort is needed from law-makers, policy makers and all levels of public and private institutions. It is vital that people with mental health issues or addictions are at the table and represented in efforts to make change.

> **Peer support is also about saying that we need to be included at the table.**
>
> – Participant in Ottawa roundtable session

This report makes recommendations to government, employers, housing providers, service providers and others to review and remove the barriers that lead to human rights concerns. The report also outlines the steps the OHRC will take to address discrimination and harassment in this area.

We were told that much more concrete guidance is needed to help eradicate discriminatory attitudes, ensure accountability and educate individuals, organizations and the general public about their rights and responsibilities under the *Code*. The OHRC will work with multiple stakeholders to address these needs.

2. Background

The courts have long recognized the historical oppression of people experiencing mental illness or mental health disabilities.[1] In the Supreme Court of Canada case, *R. v. Swain*, Chief Justice Lamer wrote:

> The mentally ill have historically been the subjects of abuse, neglect and discrimination in our society. The stigma of mental illness can be very damaging. The intervener, [Canadian Disability Rights Council], describes the historical treatment of the mentally ill as follows:
>
> > For centuries, persons with a mental disability have been systematically isolated, segregated from the mainstream of society, devalued, ridiculed, and excluded from participation in ordinary social and political processes.
>
> The above description is, in my view, unfortunately accurate and appears to stem from an irrational fear of the mentally ill in our society.[2]

Mental health and addiction disabilities, such as schizophrenia, bipolar disorder, depression and alcohol addiction, have often been met with misunderstanding, ignorance and fear. Since the 1960s, consumer/survivor[3] groups and other organizations have worked to advance the civil rights of people involved with the psychiatric system and challenge these attitudes. Because of widespread negative stereotypes and lack of societal acceptance of these disabilities, people with mental health or addiction disabilities may face a complex set of difficulties when realizing and asserting their rights on a day-to-day basis.

All people with disabilities have the same rights to equal opportunities under the *Code*, whether their disabilities are visible or not. People with mental health issues and addictions are a diverse group, and experience disability, impairment and societal barriers in many different ways. Disabilities are often "invisible" and episodic, with people sometimes experiencing periods of wellness and periods of disability.

In addition to the *Code*, the *Accessibility for Ontarians with Disabilities Act, 2005 (AODA)*[4] addresses the right to equal opportunity and inclusion for people with disabilities. The *AODA*'s goal is to make Ontario fully accessible by 2025. It introduces a series of standards (customer service, transportation, built environment, employment and information and communications) that public and private organizations must implement within certain timelines.

The *AODA* is an important piece of legislation that can improve accessibility in employment, services and in public life for people with disabilities. However, it can still be improved to fully reflect the spirit and requirements under the *Code*. For example, human rights principles must be taken into account to ensure that the *AODA*'s accessibility requirements include people with mental health issues.[5] To see more of the OHRC's comments on the *AODA* standards, visit www.ohrc.on.ca.

Realizing people's dignity, worth and self-determination on an equal basis with others is fundamental to advancing the human rights of people with mental health disabilities and addictions. These principles form a critical part of international human rights treaties such as the United Nations' (UN) *Convention on the Rights of Persons with Disabilities* (*CRPD* – see section 1.6.3 for more details). Dignity and equality form the foundation of the *Code*. The challenge is to make sure legal rights and principles become a reality for people with mental health issues and addictions across Ontario.

2.1. Increasing awareness about disparities

At the provincial and federal levels, more attention is being paid to the adequacy and coordination of mental health and other support services. In 2003, the Standing Senate Committee on Social Affairs, Science and Technology (Senate Committee) held a nation-wide consultation. In 2006 it released "*Out of the shadows at last*" (the Kirby report), and in 2012, released the first national mental health strategy, with wide-reaching recommendations for mental health reform. In 2008, Ontario's Minister of Health and Long-Term Care established an advisory group to develop a 10-year strategy to improve mental health and addiction services in Ontario. It released its mental health and addictions strategy in 2011.

In addition to a focus on service delivery, the federal and Ontario governments looked at the stigma and social exclusion that people with mental health disabilities and addictions face. Both levels of government have made mental health a priority, with the federal government establishing the Mental Health Commission of Canada and the Ontario government adopting a mental health and addictions strategy. Both levels of government committed to changing negative attitudes across multiple sectors, such as with youth and in health care.[6]

> **People are ready to have a conversation about mental health – but we've got a long way to go where biases and stereotypes about mental health and addictions are concerned.**
>
> – Barbara Hall,
> Chief Commissioner, OHRC

3. OHRC Methodology

In 2009, to establish a plan to address systemic discrimination based on mental health, the OHRC developed and released a consultation paper, received written submissions and conducted in-depth interviews. This feedback led the OHRC to hold a consultation to develop a policy on human rights and mental health. The policy consultation took place over several months in 2010 and 2011. It included interviews, focus groups, round-table sessions (in Toronto, Windsor, Ottawa and North Bay), a call for written submissions and an online and mail-in survey. We received approximately 1,500 verbal and written submissions from individuals and organizations, including people with mental health disabilities or addictions, advocates, housing providers, families, service providers and employers. This report also reflects the submissions that we received in 2009.

We received more submissions during this consultation than in any other OHRC policy consultation completed to date. We especially acknowledge the contribution of more than 1,000 people who identified themselves as having mental health issues or addictions, and the work that community organizations did to help us gather information from the people they serve.

Although large numbers of people and organizations came forward to express their experiences, many were reluctant to disclose their identities due to concerns about negative attitudes and stereotypes. As a result, we invited individuals and some organizations to make oral or written submissions anonymously. The Appendix includes a list of organizations that made written submissions.

Some perspectives were not as well represented as others. Although the OHRC held extra sessions to ensure adequate representation of employers, service providers and social and private housing providers, employers as a group were underrepresented compared to other organizations. In addition, in response to our questions, participants came forward with their perceptions of discriminatory treatment. Only a minority of participants described having no concerns about discrimination. Finally, while consultees' concerns are described in this report, we often were not able to report a response to these concerns.

This report includes quotes and narratives from individuals as well as from organizations. Many quotes are from people with mental health disabilities or addictions.

We are aware that using narratives can be a contentious issue. Personal narratives of consumer/survivors and people with addictions have been exploited, "sanitized," sensationalized and used to advance organizations' agendas.[7] We tried to avoid doing this by ensuring that people knew how their submissions would be used and making them anonymous. We have interpreted these using a human rights lens. We wanted to reflect people's perspectives in their own voices, as this can be a powerful educational tool.

As we move forward with our work, we look forward to hearing how people's perspectives can be represented in a way that continues to respect people's dignity and human rights.

3.1. Recommendations and OHRC commitments

Eliminating discrimination requires many people and organizations to take part. We urge government, public sector and private sector organizations to act now to eliminate the human rights concerns identified. The recommendations are not exhaustive. There is no doubt that much more can be done to ensure that the shift in thinking about mental health results in real human rights change.

The OHRC will provide support and guidance to help organizations fulfill the recommendations made. Sometimes it was not immediately clear what recommendations would be appropriate to address the concerns from a systemic perspective. However, even where the OHRC does not make particular recommendations or commitments following a specific section of the report, organizations and individuals should assess their own practices and work toward inclusion for people with psycho-social disabilities. This can also help to avoid potential human rights claims.

The OHRC also makes its own commitments for action. Recommendations and commitments were based on:

- Feedback and recommendations from consultees
- If the *Code* or other human rights instruments (e.g. the *CRPD*) clearly apply to the concerns
- Whether the recommendations or commitments build on the OHRC's existing work
- Whether the concerns raise emerging and complex human rights issues, or issues where there was "glaring unfairness"
- The organizations that the OHRC believes to be well-placed to address these concerns (whether it is the OHRC or other parties)
- The understanding that in some cases, more research may be needed to clearly understand if the concerns violate the *Code*, or multiple perspectives need to be considered before acting on the issue.

OHRC commitment:

C1. The OHRC will notify the organizations about the recommendations it has made, and offer to assist in implementing these, where possible.

4. Scope

In defining our scope, we relied on a broad concept of disability, which reflects the *Code* and a social and human rights approach to disability. The human rights approach aims to achieve equality and inclusion for persons with disabilities by removing barriers and creating a climate of respect and understanding.[8] The social approach is supported by case law and is reflected in the *Convention on the Rights of Persons with Disabilities (CRPD)*.

The *CRPD* recognizes that "disability is an evolving concept and that disability results from the interaction between persons with impairments and attitudinal and environmental barriers that hinder their full and effective participation in society on an equal basis with others."[9] The definition includes but is not limited to people who have long-term "mental impairments."[10]

This approach to disability is also reflected in a landmark human rights case (*Mercier*) at the Supreme Court of Canada. It used an equality-based framework of disability that takes into account evolving biomedical, social and technological developments, and emphasized human dignity, respect and the right to equality. The Court made it clear that disability must be interpreted to include its subjective component, as discrimination may be based as much on perceptions, myths and stereotypes, as on the existence of actual functional limitations.[11]

Using this approach, the OHRC applied a broad definition to mental health issues[12] and addictions for this consultation. Under the *Code*, disability includes a "mental disorder" or a "condition of mental impairment," but the *Code* does not list all conditions that could be considered a disability.[13] Many of the people we heard from had been diagnosed with, or previously had, a psychiatric disability or addiction, were labelled by others as having a psychiatric disability or addiction, had been involved with the mental health system or in general identified themselves as having mental health issues, mental illness or addictions.

Mental health and addictions cover a broad range, including severe and less severe disabilities and emerging disabilities. We heard from people with depression, anxiety disorders, bipolar disorder, eating disorders, drug addiction, alcohol addiction, schizophrenia, postpartum depression or borderline personality disorders, or multiple disabilities. We also heard from advocates and family members.

We also considered submissions from individuals and organizations representing people who had neurological conditions causing dementia, such as Alzheimer's disease and Huntington's chorea. Finally, we reviewed submissions from people with developmental disabilities such as autism spectrum disorder and fetal alcohol spectrum disorder who identified as having a mental health issue or addiction. Not everyone said they had some kind of impairment. Some people talked about their past mental health issue or addiction, or about how others perceived them to have a mental health disability or addiction. Past or perceived disabilities are also protected under the *Code*.

We chose to limit our focus to the experiences of people with mental health issues and addictions due to the particular forms of discrimination faced by these groups. But we know that people with other types of disabilities (such as intellectual or cognitive disabilities) can face similar experiences of discrimination, restrictions of their autonomy rights, historical disadvantage and stereotyping about their skills and abilities. These disabilities may also intersect with mental health (for example, in the case of people with dual diagnoses).

4.1. People with addictions

People with addictions[14] (for example, drug addiction, alcohol addiction or problem gambling[15]) can experience similar or distinct forms of marginalization compared to people with only mental health issues. We heard that people face a general lack of societal acceptance, negative stereotyping and criminalization of their addictions.

Laws and programs may create certain restrictions for people with addictions, compared to people with other types of disabilities. For example, people with different mental health disabilities may be eligible to receive disability benefits under the Ontario Disability Support Program (ODSP). Until recently, ODSP eligibility requirements excluded people who were disabled solely because of their dependence on drugs or alcohol. But the Ontario Court of Appeal has upheld prior decisions that found it was discriminatory and contrary to the *Code* to deny income support to people with alcohol or substance addictions because of assumed characteristics.[16] The rulings rejected the government's argument that the purpose of denying disability benefits was to help people overcome their substance abuse problem.

Because of these unique experiences of discrimination, this group needs special consideration. People with addiction disabilities have the same human rights protections as people with other types of disabilities. However, there is still debate in human rights law over different forms of addiction and whether these constitute disabilities.[17] There is often significant cross-over between addictions and mental health.[18] Although many of the human rights issues facing these groups are similar, we were told that it was important to recognize that people with addictions and people with mental health issues often identify as distinct equity-seeking groups.

> When it comes to methadone, there are still stereotypes about the substances you were taking - you can't be trusted; you don't have a grip on reality; you're invisible or you're a problem. If you have that kind of history, you have to be the problem.
>
> – Focus group participant

5. Using language

Language is an indicator of the current social and political climate for people with disabilities. We heard that terminology can perpetuate inequality or promote acceptance and inclusion. ARCH Disability Law Centre (ARCH) told us, "beyond reflecting particular ideologies, language can transform how we conceptualize mental health."

Terms describing people with mental health issues have evolved based on medical developments, people's experiences with the psychiatric system, and the activism arising out of the anti-psychiatry ex-patients' movement for civil rights.[19] The medical model assumes that mental health concerns reside within the person and may be overcome by medical experts assessing and attempting to "fix" the impairment leading to disability.[20] In our consultation, many people rejected being defined by a medical condition or in relation to the psychiatric system, because it did not capture their experiences as whole individuals. Although many used medical language to describe their disabilities, some people saw medical labels as victimizing.

Some participants did not identify as having a disability or a psychiatric disability. This occurred in part because they did not experience barriers that negatively affected them; they did not identify with the label; they felt the description implied that they are chronically unwell, which removed a sense of hope; or they generally rejected the concept of "mental illness."

> **I have a diagnosis but don't consider myself disabled; the person next to me could have the same diagnosis and be disabled. At what point is it a disability?**
> – Representative from Ontario Peer Development Initiative (OPDI)

During our 2009 consultation, we were told that any terms used should:

- Reflect domestic and international human rights protections for people with disabilities
- Appeal to people who may or may not seek treatment
- Be the ones used by the consumer/survivor movement
- Reflect a social versus medical approach to disability
- Reflect health (instead of emphasizing impairment).

During our consultation, people identified themselves in many different ways. There is still debate on how best to describe people with mental health or addictions.[21] After consulting with disability groups, the Government of Canada recommended using the term "person with a mental health disability."[22]

Internationally and in the academic literature, the term "psychosocial disability" has started to gain acceptance. The World Network of Users and Survivors of Psychiatry (WNUSP) has adopted this term as a move away from a model of individual pathology, noting:

> The psychological component refers to ways of thinking and processing our experiences and our perception of the world around us. The social/cultural component refers to societal and cultural limits for behaviour that interact with those psychological differences/madness as well as the stigma that the society attaches to labelling us as disabled.[23]

This term is consistent with a social or human rights approach to disability.

Taking these principles into account, we will refer to individual consultees with the terms they used to describe themselves. For identifying people as a group, we will use the terms "mental health disability," "mental health issues," "psychiatric disabilities" and "consumer/survivors." We will also refer to "addictions," "addiction disabilities," "people with addictions," and will use "psychosocial disabilities" to refer to both mental health issues and addictions.

6. Human rights protections

We heard that many people with psychosocial disabilities are unaware of their human rights. Some people identified experiences that extended beyond the right to be free from discrimination. Because of this, it is important to understand how people's experiences relate to human rights protected under domestic and international human rights documents.

6.1. The Ontario *Human Rights Code (Code)*

Under the *Code*, people with mental health disabilities or addictions have the right to be free from discrimination and harassment under the ground of disability in five social areas: housing, employment, goods, services and facilities, contracts, and membership in unions, trade and professional associations. In this consultation, we focused on housing, employment and services to understand the depth of people's experiences in these areas.

Discrimination is defined in many different ways. Discrimination includes any distinction, including any exclusion, restriction or preference based on a prohibited *Code* ground, that impairs the recognition of human rights and fundamental freedoms.[24] Discrimination can be direct, indirect, or it can be the result of seemingly neutral policies, qualifications, requirements, standards or rules that, in fact, exclude or disadvantage people with mental health disabilities or addictions (section 11). To determine this, we must consider whether the needs of the individual or group could be accommodated without undue hardship.[25] The *Code* also sets out the duty to accommodate based on disability (section 17). It is not discriminatory to refuse a service, job or housing because the person with a disability cannot fulfill the essential requirements. However, a person will only be considered incapable if their disability-related needs cannot be accommodated without undue hardship.

People who are associated with someone with a mental health disability or addiction (for example, friends or family) are also protected from discrimination based on their association (section 12). People are also protected from reprisal if they assert their *Code* rights (section 8).

6.2. The *Canadian Charter of Rights and Freedoms*

The *Canadian Charter of Rights and Freedoms* guarantees people's civil, political and equality rights in the policies, practices and legislation of all levels of government. Certain rights may particularly apply to people with psychosocial disabilities in certain circumstances, due to legislation and policies that focus on these groups.

Under section 7 of the *Charter*, all people have the right to life, liberty and security of the person.[26] This section was used to advance the current understanding of the rights of people with mental capacity to refuse to consent to treatment.[27] Section 9 protects people against being detained or imprisoned arbitrarily, or with no good reason, and section 10 outlines one's rights upon arrest or detention. These rights must be respected by organizations that carry out government policies, like police or hospitals, that may seek to detain people with mental health disabilities.[28]

Section 15 guarantees people the right to equal protection under the law and equal benefit of the law, without discrimination based on mental or physical disability, among other grounds. This section is similar to the purpose of the *Code*. Rights under the *Charter* are guaranteed unless violations can be justified under section 1, which considers whether the *Charter* violation is reasonable in the circumstances.

6.3. The United Nations' *Convention on the Rights of Persons with Disabilities (CRPD)*

In 2010, Canada ratified the *CRPD*, an international treaty designed to "promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity."[29] The *CRPD* moves away from considering people with disabilities as recipients of charity towards being holders of rights. It emphasizes non-discrimination, legal equality and inclusion. Countries that have ratified or signed their acceptance to the *CRPD* are known as States Parties.

International treaties and conventions are not part of Canadian law unless they have been put into legislation.[30] However, the Supreme Court of Canada has stated that international law helps give meaning and context to Canadian law. The Court said that domestic law (which includes the *Code* and the *Charter*) should be interpreted to be consistent with Canada's international commitments.[31] The *CRPD* is an important human rights tool that puts positive obligations on Canada to ensure that people with disabilities have equal opportunity in all areas of life. To meet the obligations under the *CRPD*, Canada and Ontario should put in place community supports and accommodations to allow for equal opportunities for people with disabilities, and should evaluate legislation, standards, programs and practices to make sure rights are respected.

All of the articles in the *CRPD* are relevant to the lives of people with psychosocial disabilities, but some apply particularly to the issues raised in the consultation. These include rights to:

- Accessibility (Article 9)
- Equal recognition before the law (Article 12)
- Liberty and security of the person (Article 14)
- Live independently and be included in the community (Article 19)
- Health, habilitation and rehabilitation (Articles 25 and 26)
- An adequate standard of living and social protection (Article 27).

Canada has not signed the Optional protocol of the *CRPD*, which means that people cannot complain directly to the UN Committee on the Rights of Persons with Disabilities. However, there are reporting requirements for the *CRPD*. The Canadian Association of Statutory Human Rights Agencies (CASHRA) has called on all levels of government to fulfill their obligations. This includes consulting and involving persons with disabilities and representative organizations to monitor the *CRPD*'s implementation, identifying initiatives and developing plans to show how they will address *CRPD* rights and obligations.

Throughout our consultation, individuals and groups identified themes and principles that can inform a human rights-based approach to issues affecting people with psychiatric disabilities and addictions. These reflect the *Code* and build upon many of the principles that underlie the *CRPD*, including:

- Respect for dignity
- Individual autonomy
- Non-discrimination and equality of opportunity
- Full and effective participation in society
- Respect for individual differences.

> Dignity and respect are paramount.
>
> – Survey respondent

Recommendations:

1. The Government of Ontario should address its obligations under the *Convention on the Rights of Persons with Disabilities* **in full** to promote human rights and fundamental freedoms for all persons with psychosocial disabilities. This includes actively promoting an environment where people with psychosocial disabilities can and are encouraged to take a full part in the conduct of public affairs (Article 29).

2. The Government of Ontario should measure and report to the public of Ontario on the inequities that create the conditions for discrimination against people with mental health disabilities or addictions (such as unemployment and low income) and efforts to address these conditions. Such a report should be submitted to the federal government as part of its reporting requirements under Article 35 of the *CRPD*.

PART B:

What we heard

7. Stereotypes about people with mental health or addiction disabilities

> **People are very judgmental and refer to you as "lazy" and "crazy." People think we "lack motivation," "if only we'd try harder" or "snap out of" our depression.**
>
> – People Advocating for Change through Empowerment (PACE)

Stereotypes are assumptions about individuals based on the presumed qualities of the group they belong to. Stereotypes can lead to inaccurate assessments of people's personal characteristics. Throughout the consultation, participants told how they were exposed to negative stereotypes based on disability, and subject to the "stigma" of mental health issues and addictions.[32] Stereotyping may be the basis for discriminatory acts by individuals. But it can also lead institutions to develop policies, procedures, and decision-making processes that exclude or marginalize people with psychosocial disabilities. This is a type of "systemic discrimination."

Stereotypes about people with disabilities arise from a wide-spread belief system called "ableism." Ableism refers to attitudes in society that devalue and limit the potential of persons with disabilities. People with disabilities are assumed to be less worthy of respect and consideration, less able to contribute and take part, and of less value than others. Ableism can be conscious or unconscious and is embedded in institutions, systems or the broader culture of a society.[33] Although ableism can affect all people with disabilities, people with psychosocial disabilities experience unique forms of stereotyping.[34]

There are a number of widely-held stereotypes about people with psychosocial disabilities; for example, characterizing all people with mental illness as violent or unpredictable when most are not. In reviewing the literature, CMHA Ontario points out the complexities of estimating the rates of violence by people with mental illness due to the different types of research methods used and indicates that a definitive causal relationship between mental illness and violence has not been established.[35]

> **Every time there is an incident and it comes out in the media and they say, "manic depressive" or "bipolar disorder" ... It just means now I can't tell more people.**
>
> – Toronto roundtable participant

CMHA Sudbury-Manitoulin and others said that the media play an important role in perpetuating stereotypes and shaping public opinion. CMHA Ontario recommends that the media develop a balanced approach to reporting on mental health, making sure to include the perspectives of consumer/survivors, family members and care providers.[36]

Some submissions told of being considered a security risk based on assumptions about their disability. Where there is no real evidence of risk, this type of behaviour may be a form of "profiling" based on mental health. For example, one service provider was concerned about hospitals that routinely called security personnel to be present if patients' files revealed a mental health diagnosis.

Other stereotypes about people with mental health disabilities or addictions are that they lack credibility, are not able to accurately assess situations, and cannot make decisions about their own lives. Some said these assumptions related to their concerns about the medical approach to disability. Some people criticized the medical model, saying that it pathologizes people with disabilities and assumes that they are not experts of their own experiences. This perpetuates the notion that people with mental health issues or addictions are less worthy than other people.

People said that pervasive paternalistic attitudes devalue their experiences, thoughts and choices, and lead to society having low expectations of people with mental health issues or addictions. It is hard to complain or assert yourself or your rights because your experiences are minimized and attributed to your disabilities, we were told.

> **Every attempt to question, understand or challenge the diagnosis that I felt was woefully inaccurate was met by a smug smile, "expertise," and a dismissal. I have never felt so disempowered, hopeless, helpless and suicidal as I did then. Every single feeling, experience, or thought I have that my psychiatrist does not like, no matter how valid, healthy or normal it is, is rendered completely and utterly irrelevant. I do not matter.**
>
> – Survey respondent

> **If [you] are not doing well, and if you feel you have been discriminated against, these responses are invalidated. For example, I've heard from clinical staff that instead of someone with a mental health issue having a valid complaint, the person is being "triggered" [where something causes the onset of disability-related symptoms]. That is very frustrating, because it's hard to prove your feelings are valid.**
>
> – Consumer/survivor advocate

Other prejudices about people with mental health disabilities and addictions include that people have brought disabilities upon themselves because they are of weak moral character,[37] are not as intelligent, or are "less human" than other people. In addition, physical illnesses may be seen as "more legitimate" than psychiatric disabilities or addictions.[38] All of these misperceptions can lead to discriminatory attitudes and inequitable treatment.

Certain types of disabilities are more stigmatizing than others due to the stereotypes associated with them. We were told that people with addictions are generally seen in a more negative light than people with mental health disabilities because of assumptions about how much they are personally responsible for their disability, and assumptions about their involvement with crime.[39]

People with schizophrenia or drug addictions may experience particularly negative attitudes from others based on beliefs about dangerousness, anti-social behaviour or risk.

Because of stereotyping, many people we heard from reported a fear of disclosing their disability to others. Many reported being labelled, experiencing negative attitudes from others, losing their jobs or housing, or experiencing unequal treatment in services after disclosing a mental health issue or addiction. Fear of discrimination can also result in people not seeking support for a mental health issue or addiction.[40]

7.1. Challenging stereotypes

Many people strongly recommended that the OHRC and other institutions educate the public to dispel stereotypes and teach people about human rights and mental health and addiction issues. One effective way to change negative attitudes about mental health is to have person-to-person contact with consumer/survivors or people with addictions. A report on anti-stigma recommends targeting carefully defined groups, such as health care providers, establishing organizational leadership and involving consumer/survivors in developing and leading any initiative.[41]

However, other people emphasized that rights must be enforced. Training on its own is not likely to effect change on a systemic level. Research has shown that education on mental health alone is not effective in changing people's behaviour over the long term, and should be complemented with other approaches.[42]

Recommendation:

3. Organizations and individuals across Ontario should work to enhance efforts to challenge stereotypes about people with mental health issues or addictions by implementing and actively taking part in anti-stigma and education campaigns.

OHRC commitments:

C2. The OHRC will work with community stakeholders to enhance public education on human rights and mental health.

C3. The OHRC will conduct training on its policy on mental health and addictions throughout the province with consumer/survivors, people with addictions, government, as well as public and private-sector organizations.

8. Socio-economic status, mental health and addictions

> What has allowed for my accomplishments and some semblance of a quality of life distinctly relates to supportive family and class… But take that security away and my mental health would deteriorate very fast. I could very well be homeless – there were periods of time when I couldn't organize my thoughts to eat properly. The fact that in a province like Ontario people with invisible disabilities can be penalized for being ill is in itself a poor testament to our human rights.
>
> – Survey respondent

Many individuals and organizations talked about people's experiences with poverty. Poverty is a significant concern for people across Ontario with psychosocial disabilities. Unemployment, underemployment, discrimination and the lack of affordable housing for people with psychosocial disabilities were identified as major factors contributing to poverty. Statistics Canada data from the 2006 Participation and Activity Limitation Survey (PALS) shows that 27% percent of people in Ontario with "emotional" disabilities[43] live with low income[44] compared to people with other types of disabilities (10%) and people who did not report having disabilities (11%).

We were told that disability-related discrimination in housing, education and employment contributes to having low socio-economic status and fewer life choices. The Advocacy Centre for Tenants Ontario (ACTO) and many individual consultees explained how living in poverty leads to further experiences of discrimination or social exclusion, and affects people's physical and mental health. We heard how policies that affect people living with low income (for example, needing to use a telephone to contact a service provider) will often have a negative effect on people with psychiatric disabilities or addictions more than others. We heard that people living with low incomes have a much harder time accessing services, housing and employment than other people.

There are clear links between poverty, mental health, addictions and other *Code* grounds. In general, people identified by *Code* grounds are more likely to have low incomes than other people. The Registered

Nurses Association of Ontario (RNAO) identified groups who are particularly at risk for low income, and the negative health effects associated with it: lone parents (most frequently mothers), recent immigrants, persons with a work-limiting disability, Aboriginal Peoples, women, people who do not complete high school, and racialized people.[45] Because of the close connection between low social and economic status and membership in a *Code*-protected group, measures that subject people with low social and economic status to inequitable treatment may raise human rights concerns. Government, policy-makers and organizations should make sure that their policies and practices do not have an adverse impact on people identified by *Code* grounds.

We heard concerns that Canada is not meeting its international obligations to protect the right to an adequate standard of living, one of the social rights included in the *International Covenant on Economic, Social and Cultural Rights* (*ICESCR*). The Registered Nurses Association of Ontario (RNAO) said this failure, by the federal and provincial governments, has been well documented by the UN Committee on Economic, Social and Cultural Rights, and by the UN's Human Rights Council's Special Rapporteur, who reported concerns on the state of adequate housing in Canada in 2007.

In 2004, the UN Committee on Economic, Social and Cultural Rights (CESCR) identified high rates of poverty for marginalized people in Canada, including people with disabilities.[46] The Ontario Hospital Association (OHA) said that Ontario and Canada should continue to invest in efforts to eliminate social disparities, which are viewed as the root of a majority of health care issues, including mental health issues and addictions.

The *Convention on the Rights of Persons with Disabilities* recognizes that people with disabilities tend to live in poverty. Article 28 outlines the right to an adequate standard of living and social protection, including food, clothing and housing, without discrimination because of disability. By ratifying the *CRPD*, Canada has made a commitment to safeguard these rights, including ensuring access to poverty reduction programs, retirement benefits and programs, appropriate and affordable services, and financial assistance.[47]

ACTO and the RNAO called for explicit protection for people with low income in existing human rights legislation by adding "socio-economic status" as a prohibited ground of discrimination in the *Code*.

In 2009, the Ontario Legislature passed the *Poverty Reduction Act, 2009*[48] which commits the Government of Ontario to implementing its poverty reduction strategy (launched in 2008) and measuring and reporting on its progress. The Act says the poverty reduction strategy must recognize the heightened risk of poverty for people with disabilities, among other groups, and that people with disabilities must be regularly consulted on the strategy.[49] Although the province created a primary focus on reducing child poverty, including increasing access to mental health services for children and youth, it is not yet clear if these measures have made a difference in the lives of people with mental health issues and addictions. The recent economic downturn has meant cuts and budget freezes for housing and services that assist low-income Ontarians that will likely have an impact on poverty-reduction measures.[50]

> **On the low income provided by social assistance you can't get proper food. Proper nutrition is especially important for people dealing with mental health challenges.**
>
> – Participant in North Bay roundtable session

We were told that that low incomes cannot keep pace with the real cost of living. ARCH pointed to the difference between the shelter allowance provided by Ontario Works and Ontario Disability Support Program, and the actual rents charged for adequate housing around the province. CMHA Ontario said that a large number of Ontarians with mental health issues receive social assistance benefits that place them well below the poverty line.[51] Consultees told us that when receiving social assistance, people have very little left after paying for rent and other basic needs, such as food.

The social assistance system in Ontario is currently (2012) undergoing a review – one of the commitments made in the Poverty Reduction Strategy. In its 2008 report on its human rights and housing consultation, *Right At Home*, the OHRC recommended that the Government of Ontario review and improve funding rates, programs, laws and regulations to make sure that low-income tenants are able to afford average rents, food and other basic necessities. People with low income, including people with psychiatric disabilities and addictions, must be able to afford the necessities of life.

Recommendations:

4. The Government of Ontario, whenever considering budget restraint measures that affect services, housing and employment for people with low income, should particularly take into account the goals identified in the Poverty Reduction Strategy and the needs of people with psychosocial disabilities, people living in poverty, and other groups protected by the *Code*.

5. The Government of Ontario should enhance and improve social assistance, including reviewing and improving benefits, to make sure that people can afford the necessities of life such as food, clothing, adequate shelter and other needs.

9. Mental health, addictions and intersecting *Code* grounds

A significant theme in the consultation was how a person's identity, based on mental health or addictions, intersects with other *Code*-related aspects of identity (such as race, sex or age), which can be the basis for unique or distinct forms of discrimination. People told us it was much harder to get a job, housing, or services because of discrimination based on two or more *Code* grounds. For example, we heard that young African Canadian men with a psychiatric disability find it harder to get housing due to stereotypes related to race, age, gender and disability.

Many people spoke of the effects of discrimination, harassment or negative stereotypes on a person's mental health. They pointed to the profound systemic – including physical and mental health – impacts of longstanding discrimination and social exclusion on marginalized communities. The World Health Organization says:

> ...Vulnerability can lead to poor mental health. Stigma and marginalization generate poor self-esteem, low self-confidence, reduced motivation and less hope for the future. In addition, stigma and marginalization can result in isolation, which is an important risk factor for future mental health conditions. Exposure to violence and abuse can cause serious mental health problems, including depression, anxiety, psychosomatic complaints, and substance abuse disorders. Similarly, mental health is impacted detrimentally when civil, cultural, economic, political and social rights are infringed, or when people are excluded from income-generating opportunities or education.[52]

The Empowerment Council – clients and ex-clients of the Centre for Addiction and Mental Health – pointed to the importance of considering the social determinants of health to advance a human rights approach. The social determinants of health help to explain how inequities in social factors affect mental health. These determinants include housing, health care services, food security, gender, country of origin, exposure to discrimination and racism, and education.[53]

We were told it is very hard to get appropriate health care and support services that provide "culturally competent" services – that is, that respect and meet the specific needs of different communities being served.[54] Services are often designed based on mainstream models that do not consider people from marginalized communities, or cultural differences in perspectives, frameworks and definitions of mental health.[55] This can lead organizations to unintentionally discriminate against people from racialized and immigrant communities, Aboriginal Peoples, people who are gay, lesbian, bisexual, transgender people and other people based on *Code* grounds. Services may have exclusionary policies, procedures, decision-making practices and an organizational culture that is not inclusive.

The Ontario Federation of Indian Friendship Centres (OFIFC) said a lack of culturally appropriate services may result in poorer care, and indirectly contribute to people's deteriorating mental health. Racial stereotyping or a lack of understanding of specific cultures and communities during intake and assessment can lead to misdiagnosis, poor diagnosis or poor treatment of people from racialized communities.[56]

We heard about several instances of differential treatment because of a lack of cultural competency. We heard that people who are gay, lesbian and bisexual may find it difficult to disclose their sexual orientation within psychiatric hospitals and programs because of a non-inclusive environment. This can discourage people from using these services. One Aboriginal woman said that medical doctors did not consider her preference for Aboriginal-specific and alternative medicines. She did not return, and was left with little choice for alternative care.

A representative from a Francophone agency in Ottawa said some English-speaking service providers instead of providing the services in French or providing a language interpreter, may see Francophone clients as having diminished power to communicate their wishes, and they look for someone to act or speak for them, for example, as their power-of-attorney.

> **Except in [a community mental health agency], which is not covered by OHIP, [mental health counsellors] I have met so far have very little knowledge or readiness to deal with sexuality issues (gay), and when the issues of race intersect, their knowledge was surprisingly low and I am still left without a health professional who could understand or who is really willing to understand the intersections of issues (race, gender, newcomer related) in counselling!**
>
> – Survey respondent

We also heard that people were subjected to harassing or discriminatory comments within services based on *Code* grounds.

9.1. Intersections with other types of disabilities

> Every diagnosis that you have creates another level of discrimination or barrier.
>
> – Toronto roundtable participant

People may be discriminated against based on a combination of mental health and other types of disabilities. We heard that people with both mental health issues and addictions are often looked down upon. Some said that because of a mental health issue, their physical disability will not be taken as seriously.[57]

Often mental health services are not designed to serve people with more than one disability, leaving people with multiple disabilities, such as mental health and addiction issues, developmental disabilities or learning disabilities, from receiving timely or adequate services (Learning Disorders Association of Ontario). This issue is explored in section 8 (Services). We also heard that certain medications for psychiatric disabilities, such as schizophrenia, have side-effects that can lead people to develop physical disabilities like diabetes. People could then need accommodation for both disabilities.

We heard that some people were assumed to have addictions when they exhibited certain behaviours related to a disability. Because of this, they were treated as a security risk. A few people said that security personnel and police assumed that they were using drugs or alcohol when they had symptoms of a physical disability or a mental health issue.

Some people could not get services or supportive housing – including mental health services and supports – in an equal way because their physical disabilities, such as mobility disabilities or hearing disabilities, were not accommodated.

> A client of mine was assaulted. She is Deaf and has a mental health disability. The police didn't provide an ASL interpreter, and instead of trying to listen to her about being assaulted, they took her to [a psychiatric hospital] where they assumed she was making it all up because they didn't provide her with an interpreter. So they Formed her [detained her in hospital involuntarily].
>
> – Community legal clinic representative

9.2. Intersections with sexual orientation

We heard how people face a "double burden" of coming out as gay, lesbian or bisexual and also disclosing a mental health issue. Some said the stress they experienced because of discrimination based on their sexual orientation contributed to mental health issues and addictions. Lesbian, gay and bisexual (LGB) people are at greater risk for certain mental health issues, including depression, anxiety and substance abuse disorders.[58] These often relate to experiences of discrimination.[59] LGB youth are more likely to have experienced suicidal thoughts or attempted suicide than heterosexual youth.[60]

We heard concerns about stereotypes that gay, lesbian and bisexual people are assumed to be "mentally ill," even though being gay is no longer identified as a mental illness in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV-TR). Some people told us of homophobic remarks from mental health service providers, or that their service providers lacked understanding about their experiences relating to sexual orientation.

> I was sent to a psychiatrist at [a hospital]. When I mentioned to him that I am gay and wanted to talk about it, he wasn't ready to listen, because he was "not an expert in that area"! I had to wait another five months before I met a gay-friendly counsellor at [a community mental health agency].
>
> – Survey respondent

We heard about homophobic comments from other clients within a service environment, which may be dealt with inappropriately by service providers. Within mental health services, same-sex partners may not be treated as legitimate family members, preventing them from getting information about someone receiving treatment or support.

9.3. Intersections with sex

There is a close connection between mental health disabilities, addictions and gendered violence. Women who are survivors of violence, trauma and abuse often face substance use and mental health issues.[61] Several women reported gender-based violence related to having a mental health history. Some said they were sexually harassed or assaulted by patients or staff while hospitalized for a psychiatric disability.

> At [a hospital], I was subjected to harassment from a fellow ... patient. He would appear every morning at my bed, wake me up, and point to his erection, and show me his colourful collection of condoms. Later it was discovered another woman complained of an assault. I was terrified in my bed, afraid of taking medication since I thought I'd be raped since I was sedated ... It was reported, nothing was done, [the other female patient] was discharged and he continued to harass me.
>
> – Written submission

Women with mental heath issues and addictions can be even more vulnerable to harassment or violence when they also experience poverty, age and other disabilities. In late 2011, the Ministry of Health and Long-Term Care set up a task force to address the many complaints of abuse against older adults in nursing homes, including sexual assault of female residents with dementia.[62]

Some women said their mental health concerns were minimized compared to men's mental health issues, and that mental health issues and "women's issues" are seen as the same thing. Historically, women in the West were diagnosed with "hysteria" – a so-called nervous disorder – based on their female reproductive anatomy. This provided a rationale for denying them civil and political rights.[63]

One addictions worker described negative stereotypes about women with addictions – they are assumed to be sex workers or to put themselves in situations where they contract illnesses. Women with psychiatric disabilities or addictions may face discrimination based on cultural ideals of femininity because they gain or lose weight due to their disability or the side-effects of medication.

Women's experiences with discrimination based on mental health and addictions must be understood in the context of other *Code*-related identities, including sexual orientation, race, ancestry, age, family status and having other disabilities. For example, we heard that mothers may experience multiple stereotypes or challenges based on sex, family status and disability. We were told women with addictions may be assumed to be poor parents or may be afraid to use mental health or addiction services because of concerns that child protection workers will become involved and their children will be taken from them.

9.4. Intersections with gender identity

> [At] my last job, I told my boss I was trans, and she told me flat out not to tell anyone [or] I would be fired. I can't make enough money to support myself right now, and the stress of that has a huge impact on my mental health ... The discouragement of looking for work that you are qualified for, and that you know you can do, and being turned down again and again and again, is really damaging.
>
> – Focus group participant

Transgender people told us about the major impacts on their mental health from daily discrimination, lack of societal acceptance, poverty, unaffordable housing and alienation from family, based on gender identity. A focus group co-facilitated by Rainbow Health Ontario, identified poverty as a consequence of discrimination, but also a contributing factor to poor mental health. In a study of 433 trans Ontarians, half "seriously considered" suicide because they were trans. Trans youth (up to age 24) were more than twice as likely to seriously consider suicide than trans people over age 25.[64]

People expressed their concerns with "gender identity disorder" being included in the *Diagnostic and Statistical Manual of Mental Disorders* because it treats trans people as having a mental illness. We heard that trans people are automatically believed to have mental health issues. However, there are tensions around the inclusion of "gender identity disorder" in the DSM-IV-TR. Without being diagnosed as having a disability, trans people do not have access to the Ontario Disability Support Program, funded hormones or sex-reassignment surgery. Some people said the need to transition should be considered a *physical* health issue, not a mental health issue.

Some trans people talked about having difficulty getting medical supports to undergo transition, such as hormones, because of mental health issues. They told us how their transition or hormones were seen as the cause of the mental health issue, when the mental health issue may have been linked to broader experiences of discrimination.

Some indicated they were not treated with dignity while hospitalized or receiving treatment for a mental health condition; they were not allowed to transition genders, they were sexually harassed, or segregated from other patients. They emphasized the importance of amending the *Code* to include "gender identity" as an explicit ground to ensure trans people's rights to equal treatment and full participation in society are recognized. In June 2012, "gender identity" and "gender expression" were added as grounds of discrimination in the *Code*.

9.5. Intersections with race and related grounds

> **Dealing with racism in my workplace contributed significantly to me having mental health problems in the first place.**
> – Survey respondent

> **Doctors assume that since I am female and an immigrant that I must be okay with being subjugated or treated as less than an autonomous adult.**
> – Survey respondent

We heard about the different types of intersecting discrimination occurring because of race, citizenship, ethnic origin, place of origin, ancestry, colour or creed, in addition to mental health disabilities and/or addictions. We were told how perceptions about people's disabilities can contribute to negative perceptions based on race in different ways. For example, one person told us she was labelled as the "angry Black woman" at work because of her symptoms of depression.

The Metro Toronto Chinese and Southeast Asian Legal Clinic (MTCSALC) and the New Mennonite Centre said discrimination and barriers to integration can affect the mental health of immigrants to Canada. Some people said they had difficulty disclosing their mental health issues within their community.

MTCSALC said the social stigma experienced by people with mental health and addiction issues may be more severely felt by immigrants and people from racialized[65] communities because the stigma adds to the multiple challenges they already face, not because issues are more prevalent in these communities. In a focus group organized by the Ethno-Racial Disability Coalition of Ontario (ERDCO), one participant said that having to ask for accommodation or speaking up to assert one's rights were made much more difficult when dealing with issues of racial discrimination because of power imbalances.

We were told that people from racialized communities and in particular, African Canadian men, experience harsher treatment than non-racialized people in the mental health and forensic mental health systems (where people are also involved in the judicial system). People were concerned that there is a high representation of racialized people with mental health issues in the criminal justice system, and that African Canadian men with mental health issues are more likely to enter the criminal justice system than the community mental health system.[66] One person from an agency serving racialized communities said misdiagnosis may be common because of stereotypes and cultural and language barriers.

A growing body of international research supports many of these findings.[67] Some studies suggest there are higher rates of restraint and confinement for people of African or Caribbean descent compared to people of other ethnic backgrounds, although the reasons for this may be complex.[68]

a) Language

Language is not a prohibited ground under the *Code*, but it can be related to ethnic origin or place of origin.[69] The Provincial Human Services and Justice Coordinating Committee (PHSJCC) and many others said that the lack of accommodation of language needs for people with mental health issues or addictions is a major issue.

We heard the lack of interpretation and translation can lead to not being able to access services, or being treated differently within services. Advocates said there is a systemic issue of racialized people being treated as "non-compliant" in the hospital setting when their cultural or language needs are not accommodated, and people have been treated poorly as a result (for example, they have been improperly assessed, or have had hospital privileges taken away). The PHSJCC recommends that the Ontario government develop targets to improve access to mental health and addiction services for ethno-racial communities, including improving access to language interpretation.

The French Language Health Services Network of Eastern Ontario (RSSFEO) told us that there is a documented lack of mental health-related services for Francophone people in Ontario.[70] It recommends recognizing language as an element of discrimination for anyone with a mental health disability or addiction.

b) Creed

We heard how people's creed beliefs were not accommodated in different types of services used by people with mental health issues and addictions. Some women were prohibited from wearing their hijabs in hospital due to "health and safety concerns," or had to remove their clothing in the presence of men. We also heard about some services that did not observe creed-based dietary needs. Some non-religious people said that it was hard to find addiction services that were not religion-based; one person said that, within these services, non-religious views were seen as a barrier to recovery.

9.6. Aboriginal Peoples

> I would like to see Aboriginal health advocates accompany people to places in the city because we do not always receive a good reception where we have to go. I think people are cruel towards us and the youth have no supports to help them get around and to get help.
>
> – Survey respondent

> **People do not care to understand me or my situation as related to my disability. The other parts of who I am as 2-spirit, masculine identified [and] Aboriginal play into how people treat me, even before I want to discuss my ways of coping and living with mental health diagnosis and illness.**
>
> – Survey respondent

Many organizations and individuals spoke of how Aboriginal Peoples in Canada have been affected by a long history of colonization, institutionalized racism and discrimination, such as the residential school policies. The Ontario Federation of Indian Friendship Centres (OFIFC) said that for the urban Aboriginal population, this has led to intergenerational trauma, family violence, poverty, homelessness, lack of education and incarceration. All of these have serious negative impacts on people's mental health.

Mental health issues such as suicide, depression and substance abuse are higher in many Aboriginal communities than in the overall population. The OFIFC stated that the Aboriginal suicide rate is 2.1 times the Canadian rate; Aboriginal women are three times more likely to commit suicide than their non-Aboriginal counterparts.[71] The suicide rate for Aboriginal youth aged 15 – 24 is five to six times that of the non-Aboriginal population.[72]

Stereotypes about drug and alcohol use were raised in the consultation. Many people described how they were treated unequally in services, exposed to harassing comments, or profiled as a security risk based on stereotypes about their Aboriginal identity and misperceptions about alcohol and drug use. The OFIFC said that the provincial mental health reform in the 1990s that led to hospital closures meant that many Aboriginal people with mental health issues and addictions were released into urban areas and not back to their communities of origin.

Many said lack of affordable housing was a major issue of concern and that it is much harder to get housing because of intersecting identities of having a mental health issue or addiction, and being of Aboriginal ancestry.

9.7. Intersections with age

a) Younger people

The Ontario Secondary School Teacher's Federation (OSSTF/FEESO) expressed concern that mental health services for children and youth are not mandated in Ontario, which leads to inconsistent and fragmented approaches. Younger people (under 25 years of age) who took part in the consultation said that they could not get mental health or addiction services because they were too young for adult services, too old for paediatric services, or did not meet the program criteria because they had multiple disabilities. One youth worker described how a youth addiction treatment program denies service to youth who have been involved in child protective care.

The Children's Hospital of Eastern Ontario (CHEO) said that by ratifying the *International Convention on the Rights of the Child*, Canada is obliged to ensure that children realize their rights to the highest attainable standard of health. CHEO said that Canada must strive to make sure no child is deprived of his or her access to such health care services (Article 24.1). CHEO said that it is a serious of breach of children's rights to have no legislation on children's mental health. In its Mental Health and Addictions strategy, the Ontario Ministry of Health and Long-Term Care (MOHLTC) has targeted increased service delivery for children and youth, with a focus on early detection and intervention.

b) Older adults

The Advocacy Centre for the Elderly (ACE) spoke of significant issues of discrimination facing older adults with mental health issues and addictions. Estimates are that one in five persons over age 65 has a mental health disorder.[73]

ACE is frequently contacted by older adults and substitute decision-makers because older adults in long-term care have been given medication, particularly anti-psychotic medication, without informed consent. ACE voiced concern about the high rate of anti-psychotic drug use in long-term care homes for residents with dementia compared to use among older adults with dementia living in the community.[74] ACE raised concerns about the side-effects and long-term effects of this type of medication. ACE also said that, in contrast to people covered by the *Mental Health Act*, people in long-term care do not have the same access to legal rights advisors if they are found incapable to consent to treatment. Other issues regarding long-term care are described in the section on Housing (Section 11.1.).

Others told us how discrimination based on age combines with discrimination based on disability, particularly in the area of employment. They said it is much harder to find and keep employment when dealing with the symptoms of aging and disability.

> **Although I have over 30 years of experience in administrative/secretarial/clerical along with about 25 years of organization/event planning/public relations/promotions/media ... I cannot find appropriate work due to the fact [that] I am presently only able to work 25 – 30 hours per week and I'm [around] eight years out of the work-force. Add that to the fact I'm only seven years away from the usual retirement age of 65, and many people just don't want to hire me.**
>
> – Survey respondent

Recommendation:

6. The Government of Ontario and organizations providing services to people with mental health and addictions should work to identify and eliminate discrimination based on disability in their services, as well as discrimination based on age, sex, race and related grounds, gender identity, sexual orientation and other *Code* grounds. This may require a process of examining policies, practices and decision-making processes and removing barriers that lead to discrimination for *Code*-protected groups (see the OHRC's *Guidelines on developing human rights policies and procedures* for more information).

OHRC commitments:

C4. In its work on its strategic priorities (e.g. policing and anti-racism, Aboriginal Peoples' human rights, family status, disability and education), the OHRC will build in a focus on human rights, mental health and addictions.

C5. The OHRC will further examine the issue of the level of rights advice provided to older adults in long-term care who are deemed to be incapable of making treatment decisions. If this has the potential to violate the *Code*, the OHRC will, where appropriate, raise concerns with the responsible parties, do public interest inquiries, intervene in legal cases and/or launch Commission-initiated applications.

10. The duty to accommodate

> Accommodation for employees with mental health illness in the workplace ... isn't just about hurt feelings, loss of dignity or a feeling of being treated unfair. It is about survival. It can be the straw that breaks you or it can be the hand that saves you. Not being accommodated meant that I had to use all my energy just to cope with the barriers that I identified at work, just to get through the day. At the end of the day, I was so exhausted that I could hardly drive home.
>
> – Written submission

Under the *Code*, housing providers, employers and service providers have a legal duty to accommodate the *Code*-related needs of tenants, employees and service users. They must make sure that organizations are designed inclusively, and remove any barriers that may exist, unless that would cause undue hardship. The duty to accommodate could involve making changes to organizations' policies, bylaws, practices and decision-making processes to allow for equal opportunity for people from *Code*-protected groups. The people seeking accommodation and the organizations providing accommodation both have responsibilities to participate in the process. In many cases, people with mental health issues or addictions will not need accommodation to get or keep their housing or employment, or to access services, but in other cases the duty to accommodate will arise. In these situations, the principles of dignity, individual accommodation, integration and full participation must apply.

> Unless it were to cause undue hardship, the duty to accommodate could involve, for example, soundproofing a rental unit for someone who is sensitive to sound due to posttraumatic stress disorder, allowing an employee time off from work to attend counselling, or making a service deadline flexible because the applicant has been in hospital.

We heard that there is much confusion around the duty to accommodate, for everyone involved. Many people with psychosocial disabilities are unaware of their rights to accommodation. People may be reluctant to say they have a disability and need accommodation, because they fear they will be discriminated against. One person described being so worried about stigma that they quit a job instead of asking for a needed leave of absence.

Organizations need to make sure they explicitly address stereotypes and make their organizational cultures more open to people with psychosocial disabilities. Under the *Code*, organizations have the ultimate responsibility for ensuring inclusive environments that are built or adapted to meet the needs of people with mental health disabilities and addictions and promote their full inclusion and participation. We often heard how workplaces and services in particular need to be more inclusive, "finely tuned" and accessible to people with psychosocial disabilities.

Organizations told us that they needed clear and concrete guidance on how they can provide accessible services to people with mental health disabilities and addictions. They said that this was true even with the standards of the *Accessibility for Ontarians with Disabilities Act (AODA)*, which describe how all organizations must ensure full accessibility and non-discrimination for people with disabilities.

We heard that accommodating people with mental health issues and addictions is often seen as more challenging than accommodating people with other types of disabilities. Some of these challenges are due to the stigmatization of these disabilities, their often "non-evident" nature and privacy issues that may arise. However, CMHA Sudbury-Manitoulin said that organizations should not assume that providing accommodations to address the needs of people with psychosocial disabilities is difficult or costly. It says that, "[This] is the exact opposite of the reality that accommodations are usually very simple and cost efficient. Lack of knowledge leads to fear and therefore lack of opportunity."

Organizations told us they need more information about:

- How to meet their duty to accommodate when people may not be able to identify their disability-related needs or take part in the accommodation process due to their disability
- Considering disability as a mitigating factor in situations that would otherwise result in penalizing the person
- How to assess undue hardship if an issue arises due to a disability-related behaviour (for example, a health and safety issue)
- How to balance one person's right to accommodation with others' needs and rights.

Consultees said that accommodation providers should publicize their human rights policies so there can be a better understanding of rights and responsibilities. Some pointed out that human rights enforcement is key to ensuring that *Code* violations do not occur.

Recommendations:

7. The Accessibility Directorate should consult with people with psychosocial disabilities and disability groups to evaluate the current *AODA* standards to see how well they take into account the needs of people with psychosocial disabilities. Based on the feedback from consultees, the standards should be modified to take into account any additional accessibility requirements.

8. The Accessibility Directorate should develop and promote further education materials that show how the *AODA* specifically applies to people with mental health disabilities or addictions, so organizations understand their responsibilities towards people with psychosocial disabilities.

OHRC commitment:

C6. The OHRC will develop a policy on human rights, mental health and addictions, that will build on its *Policy and guidelines on disability and the duty to accommodate*. In writing its policy, the OHRC will provide guidance, with examples, on how organizations can meet their duty to accommodate people with psychosocial disabilities at work, in housing and in services. This discussion will take into account the concerns raised in the consultation, the responsibilities of people and organizations during the accommodation process, and the limits of accommodation (undue hardship).

10.1. Identifying accommodation needs

> It's hard to know whether a client knows they have a disability, because it's stigmatized so much they may not want to disclose. That could prejudice the outcome of their case in court, for example, if the disability becomes known to the judge or the opposing party. Similarly, in court services [clients] won't want to disclose publicly their disability. Should there be an onus on a person to identify, or does a [service provider] simply notice behaviours, and if so are they just applying stereotypes?
>
> – Court services representative

> There's a fine line between accommodation and patronizing. The key is requesting the accommodation and being comfortable to request it, but not having it pushed on you "for your own good" if you're not looking for it.
>
> – Representative from OPDI

The accommodation process usually begins when someone identifies they need accommodation due to a disability-related need. Throughout the consultation, we heard that organizations need clarity on what they can or cannot ask a person with a mental health issue about any potential accommodation needs, taking into account a person's right to privacy. This was particularly true when trying to "start the conversation" when a person is perceived to have a mental health issue or addiction that is negatively affecting their work performance, tenancy, or participation in a service environment and may require accommodation.

We also heard repeatedly that people with mental health disabilities and addictions were questioned or not believed when they disclosed their disability-related needs, even when they provided medical documentation. Consultees said that people are presumed to be lying about their disabilities to shirk their responsibilities. Accommodation may then be denied on this basis. This was especially a concern for employees with mental health and addiction disabilities.

I was told that mental health issues were not a disability and no accommodation was needed. Therefore, "take the job we are offering or resign."

– Survey respondent

We heard that people with mental health issues or addictions struggle to have their disabilities acknowledged in the same way they would if they had physical disabilities, especially about information required to verify their disabilities. The Human Rights Legal Support Centre (HRLSC) said that because of the "hidden" nature of these types of disabilities, it is not always obvious that people are disabled, and people are expected to provide a higher degree of disclosure.

Respect for privacy and confidentiality were identified as critically important. People raised concerns about the amount of medical documentation that may be asked for to support an accommodation request. Because of an imbalance of power between the person asking for accommodation and an accommodation provider, as well as a lack of understanding by both parties of what information is needed for accommodation, people may feel they have no choice but to provide their personal medical information, even if this is not needed for the accommodation. People were concerned that this information can be used in inappropriate ways. The Ontario Secondary School Teacher Federation (OSSTF/FEESO) stated:

> Of particular importance to OSSTF/FEESO members are the systemic practices carried out by employers. Many employers regularly attempt to have individuals sign letters of consent allowing for full disclosure from physicians. Forms frequently ask for information about "nervous disorders," which our members sometimes in a weakened and uninformed state, sign. Employers then sometimes use the information in punitive ways.

We also heard that doctors' notes, especially from family doctors, are sometimes vague and not current, and may not give the organization the information needed to make an accommodation. The University of Guelph's Human Rights Office said:

> In providing supports for students with mental health disabilities it is sometimes difficult to obtain current and relevant documentation to either confirm a disability or support the request for unique and specific accommodations. This is particularly true when students are waiting to see psychiatrists.

There appears to be a great deal of reliance on medical information to verify that people have a mental health or addiction disability before accommodation is considered. Some people questioned this reliance, noting that organizations should take accommodation requests in good faith, and should focus on the person's assessment of what they require to be successful. Some highlighted the CIBC disability management program which, in a majority of cases, does not need medical verification of mental health-related disabilities to make a workplace accommodation.[75]

OHRC commitments:

C7. The OHRC will raise awareness with the Ontario Medical Association, the College of Physicians and Surgeons and other relevant stakeholders of how the medical community can support individuals' requests for accommodation where medical verification of a person's limitations and needs are required to make an accommodation.

C8. The OHRC will monitor emerging issues related to mental health and addictions through requests for legal intervention from the community, examining the media, networking with community organizations and the Human Rights Legal Support Centre, and other approaches. The OHRC will consider using its mandate to address these issues by, where appropriate, doing public education, policy development, launching public interest inquiries, legal interventions and/or Commission-initiated applications at the Human Rights Tribunal of Ontario.

10.2. Clarifying when the duty to accommodate applies

There is also confusion among organizations and individuals about the legal obligation under the *Code* to accommodate disability; does this mean that an accommodation provider has to provide care, treatment or counselling to someone with a psychosocial disability or addiction, or ensure their good mental health? This perspective points to a need to clarify accommodation providers' roles in meeting their duty to accommodate, to make sure that everyone understands how accommodating may be different from providing care.

Many people raised concerns about organizations that deny services or housing to people based on disability or on the complexity of people's needs. Sometimes this denial may be an example of unequal treatment, or a failure to accommodate the person's needs to the point of undue hardship. However it may be that the type of service or housing sought is clearly beyond the mandate of the organization and that accommodation may not be appropriate. The OHRC can help by providing further guidance on when and how the *Code* may apply in these situations.

OHRC commitment:

C9. In its policy on human rights, mental health and addictions, the OHRC will provide guidance on distinguishing the duty to accommodate from providing treatment or care to someone with a mental health issue or addiction. It will also provide guidance on when the *Code* may apply when organizations deny services or housing to people with psychosocial disabilities.

11. Housing

11.1. Systemic and societal issues

a) Lack of affordable housing

> This is pretty simple and straightforward ... mental health issue = public assistance for income = public housing = 8 year waiting list = only to live in a project = where I feel unsafe = so my symptoms flare = I become a danger to myself = another suicide statistic = nobody cares
>
> – Survey respondent

The lack of affordable and suitable housing across Ontario was raised by individuals with mental health and addiction disabilities, and organizations. Statistics Canada's 2006 Participation Activity Limitation Survey (PALS) shows that in Ontario, people with "emotional" disabilities are more likely to be in core housing need than the non-disabled population and people with other types of disabilities.[76] We heard many concerns about homelessness. The closing of psychiatric institutions in Ontario, together with the lack of community resources available to people who had been housed in psychiatric institutions, has led to high levels of homelessness for people with mental health and addiction issues.[77] The RNAO said that the federal government has not fulfilled its obligations to address homelessness by implementing the Kirby report's recommendations on poverty, housing and homelessness. RNAO told us there is an urgent need for the province and municipalities to bridge the gaps in public policies related to housing, income support and mental health.

> The right to housing and the state of affordable, available housing in Ontario and Canada is reported on in great depth in the OHRC's *Human rights and rental housing in Ontario: Background paper*, its housing consultation report, *Right at Home*, and in its *Policy on human rights and rental housing*.

CMHA Ontario said that maintaining safe and affordable housing can be difficult for people with mental health issues and addictions in periods of illness, and people may be unable to work and experience a loss of income. As a result, many people can only afford substandard housing that is crowded, noisy and located in undesirable neighbourhoods. The Toronto Community Housing Corporation Anti-Ableism Committee voiced concerns about people with chronic mental illnesses or addictions being "warehoused" in public housing communities, in part due to the lack of affordable private housing.

The UN Human Rights Committee has expressed concern about people with psychosocial disabilities in Canada being detained in institutions because of the lack of supportive housing in the community.[78] This finding echoed several individuals' experiences: we heard that some people have been unable to leave psychiatric hospitals, or move to less restrictive units for months or even years, because the hospital was unable to find appropriate housing. Others related how people are discharged from services into homelessness. Referencing a 2006 study, the RNAO stated that, "It is clearly unacceptable, for example, that in London, Ontario in 2002 there were at least 194 instances when people were discharged from psychiatric facilities to the street or shelters."[79]

Many people raised concerns about waiting for many years for social, supportive and co-operative housing. Submissions identified the need for more housing subsidies and increases in social assistance rates to open the door to more affordable housing (TCHC Anti-Ableism Committee). After our 2007 housing consultation, we recommended that the federal and provincial governments put in place housing strategies that include measurable targets and provide sufficient funds to accelerate progress on ending homelessness and ensuring access of all Canadians, including people with limited incomes, to adequate housing without discrimination. Since these recommendations were made, a federal national housing strategy bill was proposed but did not become law. Federal investment in affordable housing has been declining since the 1990s.[80]

Ontario released its long-term affordable housing strategy, and passed the *Strong Communities through Affordable Housing Act, 2011*, which, among other things, aims to join housing and homelessness programs. It also requires municipalities to allow more affordable housing in the form of second units.[81] However, organizations such as the Ontario Non-Profit Housing Association (ONPHA) and the Housing Network of Ontario said that the strategy does not address the need for increased investment in new housing development, or the ongoing maintenance of existing properties.[82]

Article 19 of the *Convention on the Rights of Persons with Disabilities* recognizes the right of people with disabilities to live in the community with choices equal to others. It states that States Parties (such as Canada) should take effective measures to make sure that people with disabilities are fully included and can take part in the community by, among other things, ensuring:

- People can choose their community and where they live on an equal basis with others
- Access to a range of in-residential and other community support services, including personal assistance necessary to support living and inclusion in the community.

Inadequate housing

ARCH told us that many people with psychosocial disabilities experience housing that is notoriously badly maintained; people may be reluctant to complain and then find themselves without a home. Many landlords and housing providers keep their housing in a state of good repair. However, in the case of social, supportive or co-operative housing, limited government funding can make maintaining and repairing units for existing tenants difficult.[83] Several people said poor living conditions in low-income housing (both social and private rental housing) increases people's vulnerability to abuse, harassment and to feeling unsafe. That can result in negative physical and mental health impacts, and some people may even have to leave the communities of their choice to find more affordable housing. We heard examples of poor living conditions – housing in disrepair, mould, fire hazards, bed bugs and poor heating (People Advocating for Change through Empowerment).

The lack of choice to live without supports was another theme that emerged. People told us that they may be forced to choose supervised or supportive housing when they can live without these supports. Many people may have to live in shared accommodation because of low income. Living in shared housing can be difficult for people who face negative attitudes from roommates because of their disability, or who need to live alone to accommodate their disability.

Social and supportive housing

According to the Ontario Non-Profit Housing Association, social housing is housing that is community-sponsored (for example, by local faith groups, service clubs, YMCAs, other community organizations, or by municipalities).[84] It is generally run on a non-profit basis with government capital/operating assistance.[85] Supportive housing is non-profit housing for people who need support to live independently – the frail elderly, people with mental health disabilities, addictions or developmental disabilities. Supportive housing is typically available in the form of shared settings (converted houses, clustered apartments), and offers rehabilitation-oriented support to consumer/survivors to improve their community living skills.[86] Many co-operative housing organizations also form part of the network of non-profit social housing. Social, supportive and co-operative housing can be mixed-income housing, with some units that are subsidized or rent-geared-to-income (RGI), and some with market rents.

We heard examples of how social and supportive housing opportunities can support people's right to housing and improve the lives of people with mental health disabilities and addictions. One Ottawa housing provider uses a harm-reduction model that allows people with addictions to stabilize. The rent-geared-to-income approach of social housing was described as responding to individual needs. Some social and supportive housing providers reported successfully working with tenants with mental health issues or addictions to accommodate their needs.

We were told that the lack of supportive housing units across Ontario contributes to homelessness. In addition to long wait times, we heard about a lack of supportive housing for people with mental health issues with multiple needs. Some supportive housing providers may only address certain types of disabilities (mental health disabilities but not physical disabilities or addictions). This can create additional barriers for people from certain *Code* groups and leaves them with few housing options (for example, people with mental health issues who are older and able to live semi-independently, Aboriginal women with addictions leaving prison, or people with eating disorders).

> **[Around] half of women incarcerated have a mental health issue, but may have addictions and a dual diagnosis. Even in transitional housing there may be barriers where they won't be accepted into residential programs if they have outstanding charges.**
> – Participant in Ottawa roundtable session

Some people are placed in housing that doesn't match their needs, such as younger people with mental health issues or Huntington's disease being placed in long-term care facilities (ACE).

Some submissions raised concerns about gearing housing specifically towards people with mental health issues because it reinforces separation instead of integration. We heard that living with other people in a communal setting can be extremely difficult for people with severe mental health issues, particularly if they require different levels of support, and that many people prefer privacy and living on their own. Also, due to a lack of resources, people may have little access to support in supervised housing and be subject to overcrowding (Royal Ottawa Health Care Group).

Long-term care homes

ACE told us that the lack of affordable housing has a considerable impact on older adults with mental health needs, particularly because of the complex and physical health care needs older people may have. There is a lack of accessibility in the built environment for older people with mobility impairments, and discrimination can arise in the rental housing market on multiple *Code* grounds including age and mental disability.

Psychiatric facilities may reject older adults who need a high level of care due to behavioural issues from dementia, psychiatric illness or other neurological issues. The facilities may say they do not provide long-term care. At the same time, ACE has heard that these individuals are rejected by long term-care homes because of their complex needs, even if they are eligible for long-term care. As a result, people have to live in substandard housing or remain in hospital.

ACE said that if the person is admitted into a long-term care home, the required level of care is not available, with staffing levels that are often inadequate. Despite general improvements in the long-term care sector in terms of knowledge and training, ACE contends that long-term care home staff need further training to manage behaviours and needs relating to mental illness.

Recommendations:

9. The Government of Ontario should link social assistance, including shelter allowance, to the real cost of rental housing in regions across Ontario.

10. The Government of Ontario should ensure more social housing options as well as subsidy alternatives, such as a portable housing allowance, to open up opportunities for people with low incomes in the private rental housing market and to permit greater flexibility in terms of where one may live.

11. Because people with mental health issues or addictions are disproportionately likely to be in need of housing, the Government of Ontario and municipalities should consider inclusionary zoning measures: laws and bylaws that require developers and municipalities to set aside a percentage of new housing for affordable housing, or a percentage of housing to accommodate persons living with mental health issues or addictions.

Recommendations:

The recommendations the OHRC made in *Right at Home* should be implemented, including:

12. That the Government of Canada adopt a national housing strategy, in consultation with provincial, territorial and municipal governments, that includes measurable targets and provision of sufficient funds to accelerate progress on ending homelessness and ensuring access of all Canadians, including those of limited income, to housing of an adequate standard.

13. That the Government of Ontario enhance its existing Affordable Housing Strategy by providing sufficient funds to accelerate progress on ending homelessness and ensuring access of all Ontarians, including those of limited income, to housing of an adequate standard without discrimination.

14. That the Government of Ontario review and improve funding rates, programs, laws and regulations in the Province of Ontario to make sure that low-income tenants are able to afford average rents, food and other basic necessities. Specific attention should be given to:

- Ensuring that minimum wage rates are indexed to inflation and allow a full-time earner to live above the poverty line
- Assessing impacts of rent control/ vacancy decontrol
- Address claw backs in income facilitated by the *Housing Services Act* and social assistance programs.

b) *Barriers in social and supportive housing*

We heard that the legislation and procedures that govern the delivery of social or supportive housing may create certain barriers for people with mental health issues or addictions.

Applying for supportive housing

Some mental health advocates are concerned that people with severe mental health issues are being screened out of supportive housing because they are perceived as "too much work," without considering accommodating the person to the point of undue hardship. As well, many said the process of applying for supportive housing can disadvantage consumer/survivors or people with addictions. Some said application forms for supportive housing were inaccessible and intrusive. Questions about police or prison records were seen as a barrier to obtaining social housing. Any questions about people's disabilities should be linked to necessary housing or service requirements.

Some were also concerned about the privacy of medical information, particularly when applications can be shared with other housing providers. Some people were concerned that such in-depth information is being used as a tool to discriminate against people who are seen as "hard-to-house" based on assumptions about health and safety risks, without considering accommodation needs.

> People are applying for housing, but because of the consolidated social housing database, people are rejected. People are rejected as safety risks initially by one housing provider, and then continue to be rejected by others as the information is shared.
>
> – Consumer/survivor initiative representative

ONPHA and other supportive housing providers told us that supportive housing programs have special mandates relating to disability and offer different levels of services. ONPHA said that the information requested in these forms is needed to ensure applicants with complex needs get the right supports for a successful tenancy, and to show that someone is able to live independently, as required by the *Housing Services Act, 2011*.[87] ONPHA said that this information is shared sparingly and appropriately.

This disagreement shows the need to balance privacy rights with the organization's need for information so it can respond to a person's accommodation requirements. The information requested must not create barriers based on disability.

Recommendation:

15. Supportive housing providers, working with people with mental health issues and/or addictions, should examine their application processes to ensure that the information collected is necessary and does not inadvertently create barriers for people with mental health disabilities or addictions or violate people's rights to privacy. Before rejecting an individual, each housing provider must consider its obligations under the *Code* to assess a person's individualized needs, and accommodate the person to the point of undue hardship.

Tenancy in social or supportive housing

We also heard concerns about how social or supportive housing is administered. If a person delays declaring changes in their income, it can result in their subsidy being threatened; this was also raised in our housing consultation. We heard how someone was not able to identify their change in income in time, and was threatened with eviction, even though she had been hospitalized for a mental health issue. Housing providers such as the Municipality of Chatham Kent Health and Family Services also said that the requirement to live independently is often subjective, and guidance is needed on how to interpret this section in the context of tenants with mental health and addiction disabilities. We also heard concerns about the ways in which service is provided to people with mental health issues or addictions in supportive housing. Where supports (such as mental health support) are provided by staff and tied to the unit, tenants will lose this support if they move or get evicted.

People said that the rules under the *Housing Services Act* do not make it worthwhile to work part-time. The rules permit social housing providers to raise rents to account for increases in non-benefit income, such as from employment, when this income exceeds the amount specified in regulation.[88] This is often made worse by a corresponding decrease in social assistance payments. Reports from the Metcalf Foundation describe how these rules keep people in poverty and perpetuate the need for social assistance.[89]

c) "NIMBY" discrimination

Many submissions said discriminatory opposition to affordable housing for groups protected under the *Code* ("Not-in-my-backyard" syndrome or "NIMBYism") limits affordable social and supportive housing for people with psychosocial disabilities. In *Right at Home*, we recommended that government and organizations monitor and combat NIMBY opposition. The OHRC also made its own commitments to actively challenge discriminatory NIMBYism. In February 2012, we launched a guide on human rights and zoning, entitled, *In the Zone: Housing, human rights and municipal planning*, available at www.ohrc.on.ca.

NIMBY opposition refers to opposition to housing projects based on stereotypes or negative attitudes about the people who will live in them. These are often directly related to one or more *Code* grounds. NIMBY opposition can refer to discriminatory attitudes as well as actions, laws or policies developed by a municipality.

We heard that NIMBY opposition was often directed towards supportive housing for people with psychiatric disabilities, because of community concerns that property values would go down and crime would increase. According to the York Support Services Network and York Regional Police, this is based on mistaken perceptions that link mental illness and criminality. ACTO raised concerns about separation distances (which set the distance between certain housing or service types), as these will affect the zoning of group homes, which often house people with psychiatric disabilities and addictions. ACTO said this limits the range of housing options for group home providers. Many forms of NIMBY discrimination are described in the OHRC's *Policy on Human Rights and Rental Housing* (section 2.7.2).

We also heard concerns about NIMBY opposition to homeless shelters and addiction treatment centres – services used by people with mental health disabilities and addictions. Some municipalities have passed or attempted to pass bylaws to eliminate or restrict services for people with addictions. One representative of an addiction treatment centre said that because people with addictions are perceived more negatively than other *Code*-protected groups, these restrictions are not getting as much attention as they should from government or the OHRC.

Many voiced frustration that efforts to fight NIMBYism often fall to the organizations developing affordable housing or services. The Federation of Rental Housing Providers of Ontario (FRPO) noted that clear direction is required from the provincial government to prevent discrimination at the municipal level, or else the local planning process will continue to discourage the development of affordable and supportive housing. CMHA Ontario supported amending the *Planning Act* to include a section on inclusionary zoning that will give municipalities the right to direct that a certain percentage of new development be set aside for social housing.[90] ONPHA agreed, recommending that developers and municipalities be required to set aside a percentage of new housing to house persons living with mental illness or addictions.

The OHRC also heard that the Ontario Municipal Board (OMB), which hears land-use planning disputes and has the jurisdiction to apply the *Human Rights Code*, is an important forum to ensure that human rights are respected and NIMBYism is challenged.

Recommendations:

16. As outlined in the OHRC's submission to the Ministry of Municipal Affairs and Housing, the Government of Ontario should amend the Provincial Policy Statement which provides direction on land use planning matters, to:

- Confirm a commitment to human rights
- Lay out expectations for municipalities to review and remove barriers to affordable housing development that could lead to discrimination against groups protected by the *Human Rights Code*.
- Lay out mechanisms of accountability for removing discriminatory barriers to affordable housing development.
- Outline clearer expectations that municipalities will increase affordable housing in their communities.

17. Municipalities across Ontario should review their zoning and rental housing licensing bylaws to eliminate barriers to housing and services used by people with mental health issues or addictions (such as group homes or addiction treatment centres). Municipalities should remove any non-legitimate or non-*bona fide* requirements that apply to housing or services used by people with psychosocial disabilities that do not apply to housing of a similar scale or similar types of services.

OHRC commitments:

C10. The OHRC will continue to promote its guide, *In the Zone: Housing, human rights and municipal planning* and provide education to municipal councils, planners, legal clinics, developers, neighbourhood associations, tenant associations and other stakeholders on their rights and responsibilities under the *Code* to prevent discriminatory opposition to affordable housing.

C11. As per the commitments it made in *Right at Home*, the OHRC will continue to be available to consult with community organizations, municipalities/municipal associations and the Government of Ontario to help develop and implement a province-wide strategy to address and prevent discriminatory NIMBY opposition.

C12. The OHRC will continue to use its mandate to actively challenge discriminatory NIMBY opposition through, where appropriate, working with municipal councils, conducting public interest inquiries, pursuing legal challenges, and other initiatives.

11.2. Types of discrimination against individuals

a) Rental housing screening methods

In both the private and social housing rental market, consultees identified types of screening practices that lead people with psychosocial disabilities to be turned down or subjected to different terms and conditions when renting housing. Many of these screening practices are rules based on legitimate rental criteria, but that have an adverse impact on people with psychosocial disabilities. Other screening methods may involve landlords or housing providers basing rental decisions on stereotypes about real or perceived disabilities – a form of direct discrimination. For more information about rental housing screening methods, see the *OHRC's Policy on human rights and rental housing* (section 4.1.2.).

Private housing market: Adverse effect screening techniques

We heard that if people, due to disability, have:

- Spent time in hospital, a treatment centre or in a correctional facility
- Experienced unstable, low paying, or intermittent employment
- Experienced periods of homelessness
- Low income or no credit history
- Experienced disability-related behaviour for which they were evicted,

they may be unable to meet legitimate rental criteria, such as having a sound rental or credit history, or being able to provide the required deposits. When prospective tenants need a service animal to assist them, they cannot meet landlords' illegal demands for "no pets." All of these requirements can discriminate based on disability and should give rise to the duty to accommodate.

Screening for criminal history in private rental housing is becoming more common, we were told. CMHA Sudbury-Manitoulin indicated that people with mental health issues or addictions with criminal records have a very difficult time finding housing that will accept them. In the OHRC's housing consultation, the Centre for Equality Rights in Accommodation (CERA/SRAC) said that rejecting potential tenants with criminal histories may violate the human rights of people with mental health issues if a criminal record was related to their disability. Housing providers must take into account a person's individual circumstances in these cases. We also heard of situations where landlords got information about a person's apprehension under the *Mental Health Act* when inquiring about a police record, which created a further barrier to renting housing.

Private housing market: screening techniques directly based on disability

In private rental housing, many people said they were denied housing after revealing, or being perceived to have, a mental health issue or addiction. We learned of significant barriers in this area: many people tried to get housing multiple times but were unsuccessful because of landlords' reactions. Research supports the fact that many private landlords deny housing to people with mental health disabilities.[91]

Some rental screening techniques directly discriminate against people with mental health issues and addictions. Use of guarantors is permitted in certain situations; for example, when other screening information is unavailable, or where there is a history of rental default. However, guarantors should not be requested just because the prospective tenant is a member of a *Code*-protected group. We heard of situations where people who received social assistance or had a psychiatric history were asked to have a co-signor or guarantor. Some people also described being asked for extra deposits beyond one month's rent, based on their disability.

> **When I found housing downtown, landlords refused my application on the grounds that if my health became worse, how would I pay rent? When a landlord actually accepted my application, his condition was that I would pay him $100 dollars extra, in cash. I had to find housing and I had to accept the deal he offered.**
>
> – Survey respondent

People are often asked intrusive questions by potential landlords about the nature of their disability, particularly when they receive ODSP. Many people did not know that they do not have to disclose information about their disabilities to a potential landlord. We heard how certain mistaken assumptions are made about individuals with known or perceived mental health issues and addictions, particularly where this intersects with low income, or where people may appear different from other people because of their disability. Landlords may assume that people with addictions attract drug dealers to the building. We heard how some people were wrongly stereotyped as being unable to take care of themselves, irresponsible tenants or even dangerous.

> **My son … now age 30, had these experiences in the last 15 years: denial from a cooperative housing unit on the grounds that his psychiatric disability might be a so-called "sexual" disability; [there was a] refusal to rent to him because he "looked strange"…**
>
> – Survey respondent

> **I am a landlord and I absolutely do not feel safe sharing my home with a mentally ill tenant. It is beyond belief that someone would put innocent people at risk in the general public.**
>
> – Survey respondent

Some people found it difficult to get an apartment without the help of a housing worker. At the same time, some landlords will not rent to a person if they know the candidate has been involved with a mental health agency (CMHA Sudbury-Manitoulin). Others said that their housing worker would ask landlords if they rented to people with disabilities, or tell them of their client's mental health conditions, prompting intrusive questions about the nature of their client's disability and decreasing the person's chances of being rented an apartment.

Source of income

People receiving public assistance (for example, disability benefits, student loans, social assistance, employment insurance, or Canada Pension Plan benefits) are protected from discrimination in the area of housing. Despite this, many people said they were consistently denied rental housing in the private housing market because their income was social assistance, especially Ontario Works (OW) or Ontario Disability Support Program (ODSP) benefits. They noted that having ODSP as a source of income automatically marks people as having a disability.

We heard that to get a rental apartment, some people were forced to lie about receiving social assistance or about the nature of their mental health or addiction history.

> It was very difficult to find an apartment with my fiancée. We weren't getting calls back. One landlord asked me why I was on Disability and how long and how much I received, and told me that it was because the property management needed to know everything about their tenants ... but she wasn't asking as many questions of my fiancée. My fiancée has a good job and good credit; there was no reason we shouldn't have been approved for the places we applied for. Once I stopped telling the landlords that I was on Disability, and instead that I was waiting to be approved for [the Ontario Student Assistance Program] or a student already attending school, then we got approved. I can't imagine what it would be like to try and find a place to live on my own.
>
> – Survey respondent

Some people described negative and judgemental attitudes from landlords who knew they received public assistance. People told us that landlords may be acting on misperceptions about people who receive public assistance, including that they may not be able to live independently, are receiving social assistance fraudulently, or are unreliable tenants. Sometimes people face discrimination in housing based on multiple *Code* grounds, which may be linked to intersecting stereotypes. One person stated, "I would never tell a potential landlord that I was a single, middle-aged woman on disability: the kiss of death."

Conditions to receive treatment:

> Once after a suicidal crisis [in university], I was forced to sign a contract indicating that I would continue with counselling in order to remain a resident. It was also indicated that if my condition worsened I would be evicted from residence ... To give myself lasting self-respect, I claimed an apartment off-campus.
>
> – Survey respondent

The OHRC heard that in social and supportive housing, and in the private rental market, some housing providers require tenants to take treatment or medication, or want information about medications, as a condition of receiving or maintaining housing [Empowerment Council and the Psychiatric Patient Advocacy Office (PPAO)]. ARCH raised concerns about conditions placed on social housing tenants who have been released from hospital and are under the supervision of ACT (Assertive Community Treatment) teams and subject to Community Treatment Orders (CTOs). CTOs allow people who would otherwise be detained involuntarily in hospital to be treated in the community, under certain conditions.

According to a representative of a supportive housing agency, there may be a requirement that the tenant agree to take medications as a condition of tenancy within supportive housing programs that offer a high level of assistance to tenants. The Ontario Non-Profit Housing Association said that the requirement for treatment may also be part of an eviction-prevention process when tenants have failed to meet their tenancy obligations due to a mental health or addiction disability, and medication and/or treatment supports them to live independently and meet their responsibilities. When someone is able to meet their tenancy obligations without complying with these requirements, he or she would not be evicted based on non-compliance.

Requiring mandatory treatment to start or continue a tenancy can raise human rights concerns. If a person needs housing, they may feel forced to agree to conditions not allowed by the *Code*. Capable people have the right to freely consent or not consent to take treatment. There may be some situations where asking a person to seek treatment as a condition of tenancy is justified. Housing providers should closely evaluate conditions that link housing and treatment and eliminate any that do not have a legitimate (or *bona fide*) rationale.

The Supreme Court of Canada has set out a test for determining whether a requirement or standard that results in discrimination is *bona fide* and can be justified.[92] To do this, an organization must show that the standard or requirement:

- relates to the purpose or nature of the activity being performed (such as a job)
- was adopted honestly rather than for a discriminatory reason
- is necessary to do the activity (e.g. fulfill one's role as a tenant), and
  - there isn't a more inclusive alternative that would avoid or reduce the negative effect (on *Code*-protected groups), and
  - the circumstances of the individual are still considered and accommodated as much as possible, unless there are costs or health and safety reasons that would cause undue hardship.

A "housing first" approach recognizes that housing is a protected human right. It means people can obtain social or supportive housing without having to follow treatment conditions or conditions of sobriety.[93]

OHRC commitment:

C13. The OHRC will examine the issue of mandatory treatment conditions in private, social and supportive housing in its policy on mental health and addictions and will provide further guidance to landlords and housing providers.

b) During tenancy

Inequitable treatment and harassment
Submissions identified concerns about both landlords' and housing providers' reactions to tenants with psychosocial disabilities. Although many private housing market landlords respect human rights, people noted situations where they were treated inequitably. We heard that people's privacy was not respected, with landlords inappropriately releasing information to others about a person's disability, asking about medications people were taking, or over-monitoring tenants. During our housing consultation, the Psychiatric Patient Advocate Office (PPAO) said landlords may impose their own values on the tenant with a mental health disability when they exercise their rights to enter the unit. We received similar submissions during this consultation.

We learned how people may be subject to harassing comments or conduct from the landlords based on disability that poisoned their environment (CMHA Sudbury-Manitoulin), such as being called "crazy" by their landlord. Some people said they were harassed or bullied by other tenants or neighbours because of the perception of their mental health issues, and that the landlord did not adequately respond.

People also reported being repeatedly ignored by both landlords and social housing providers when they asked for repairs to be completed. They attributed this to having a mental health issue or addiction. Some said that because of these disabilities, it is difficult for tenants to continuously ask for repairs to be made; sometimes it takes an advocate to get involved before something is done.

Eviction
In both the private and social housing market, several persons said that they or people they knew lost their housing due to having a mental health disability or addiction, which sometimes resulted in homelessness. In the private market, we heard that people with psychiatric disabilities and addictions may be threatened with eviction or evicted because landlords do not like the person's source of income or because they become aware that the tenant has a disability.

> The landlord went from being really wonderful to me, and then she talked to her sister at ODSP and found out I had mental issues. All of a sudden the house was up for sale. She started all this fuss about me destroying the property, when I had been taking care of everything ... I was definitely discriminated against because of what she found out from the ODSP office.
>
> – Focus group participant

We heard how people may be evicted or threatened with eviction for behaviour related to their disability that disturbs the "reasonable enjoyment of the premises" of other tenants. This can be grounds for eviction under the *Residential Tenancies Act*.[94] However, people described how some landlords jump to evict people with mental health disabilities or addictions before trying to take the time to resolve any issues, if they occur. In these situations, the duty to accommodate to the point of undue hardship will apply.

> My sister has schizophrenia. When she first took sick, we didn't know what was going on. When we went to ask if her rent was paid up to date, they told us that they couldn't disclose that. At the end of the month, she called, and said that they were putting all her stuff outside, and she didn't know why. We didn't know what to do – she was homeless. She ended up in the hospital. Now it has changed; [the social housing provider has] to call the emergency contact person before they evict.
>
> – Focus group participant

11.3. Housing and the duty to accommodate

We received many submissions on the housing sector and the duty to accommodate. ONPHA said that there is a need for greater clarity between OHRC policy on the duty to accommodate and the various legislative, administrative and funding requirements for social housing providers. Individuals said it sometimes can be challenging for landlords and housing providers to balance the rights of the person with the disability who requires accommodation when these may conflict with the rights of other tenants, some, or many of whom may also have mental health disabilities or addictions (FRPO, Nipissing Community Legal Clinic).

We heard about different strategies that were successful when tenants and housing providers used the accommodation process. For example, if the person's needs are complex, accommodation could be contacting outside supports or implementing a team approach, with the person's consent. Some consultees emphasized that accommodation may need to take place over a period of time. Excessive hoarding was identified as one type of behaviour that may be complex to address, due to the potential health and safety concerns.

The TCHC Anti-Ableism committee and FRPO told us that landlords and social housing providers need more resources to support a tenant to be successful and to provide relevant accommodations. They called on government to help them do this. Where accommodation calls for housing providers to work with outside agencies to support a person to maintain their tenancy, ONPHA says that in many areas of the province, timely services are not available or are unavailable.

We were called upon by a number of people to educate individuals and organizations about their rights and obligations under the *Code* to progressively realize human rights in housing (ACTO, FRPO, ONPHA). ACTO said that increased awareness among tenants of their rights in housing has the greatest potential influence on advancing human rights. FRPO recommended providing relevant education to owners, managers and others who supply rental housing. Others recommended that the housing sector establish policies and protocols on the duty to accommodate people with psychiatric disabilities and addictions and communicate these to tenants.[95]

Recommendations:

18. The Government of Ontario should support social, co-operative and private housing providers to ensure that they meet their duty to accommodate. This could include ensuring there are sufficient third-party agencies available to assist with tenants' accommodation needs.

19. Social, co-operative and for-profit housing providers should develop human rights expertise so they can provide housing-related human rights advice, mediate and investigate complaints, where appropriate, and do barrier reviews of their policies and procedures.

OHRC commitment:

C14. The OHRC will continue to provide education on human rights and rental housing to tenants, landlords, housing providers and others, and will include a focus on human rights, mental health and addictions.

12. Employment

> There is still a stigma to mental health in the workplace. As a 40-year employee I have spent more energy hiding this disorder than I have in advancing my career.
>
> – Survey respondent

Work, paid or unpaid, is a fundamental part of realizing dignity, self-determination and a person's full potential in society. In Ontario, people are protected from discrimination based on disability in employment. Employment includes paid employment, volunteer work, student internships, special job placements, and temporary, contract, seasonal or casual employment. Many consumer/survivors or people with addictions expressed their desire to work or volunteer, but could not without the accommodation they needed. Negative attitudes and stereotypes about people with psychiatric disabilities and addictions can compound other employment barriers such as lack of education or employment skills training.

The *Convention on the Rights of Persons with Disabilities* recognizes the right to work and the opportunity to make a living. This requires that workplaces be inclusive and accessible to persons with disabilities. By ratifying the *CRPD*, Canada has agreed to promote the right to work for people with disabilities, including prohibiting discrimination based on disability with regards to hiring and career advancement; promoting employment opportunities in the labour market; and protecting the rights of people with disabilities on an equal basis with others, including ensuring equal pay for equal value, and promoting safe and healthy working conditions.[96]

12.1. Systemic and societal issues

a) Unemployment and underemployment

> Twenty years of no work is too much when I was able to work the whole time.
> – Survey respondent

We heard that discrimination and loss of jobs, long periods of unemployment, low education levels, or symptoms related to disability can make it very difficult for people with psychosocial disabilities to enter or re-enter the workforce. This was especially true for people with severe disabilities. People with mental health issues and addictions have unemployment rates higher than the general population and people with other types of disabilities. Less than half of people with "emotional disabilities" are in the labour force at all (either looking for work or employed).

In 2006 in Ontario, 74% of people who did not report having a disability took part in the labour force compared with 34% of people with emotional disabilities and 35% of people with other types of disabilities.[97] The Kirby report cites surveys that show that between one-third and one-half of people with mental illnesses report being turned down for a job for which they were qualified, experienced dismissal, or were forced to resign.[98] As well, people with severe or very severe disabilities as a group appear likely to be either unemployed or employed in part-time, low-income positions, compared to people without disabilities.[99]

CMHA Ontario says that when persons with mental health issues do enter the workforce, they are relegated to low-wage jobs, which results in cycling back and forth between social assistance and unstable work. Several people described their experiences in low-paying, low-skilled jobs with few prospects for advancement or stability. Ontario Shores Centre for Mental Health Sciences (Ontario Shores) pointed out that without stable housing, employment is difficult to secure.

We also heard that when people are denied accommodation in the education setting, this will affect their employment opportunities. Barriers faced in the education system may also lead to low levels of literacy and education achievement, which will affect employment opportunities as well as the ability to locate and access services that will improve people's skills.[100]

People said that to take part in the employment sector, they needed support in employment education, re-skilling and training, and workplace programs, not just therapy and counselling. In a discussion paper on employment, the Centre for Addictions and Mental Health (CAMH) and CMHA Ontario say that critical factors need to be addressed in this area, such as:

- Eliminating discrimination in education and employment practices, including policies and practices that affect employment opportunity
- Increasing opportunities for supported employment
- Reforming federal and disability income programs to remove unintended disincentives to accessing employment.[101]

b) Social assistance and employment

We heard from many people about systemic problems with social assistance that pose significant barriers to transitioning people to paid work. One of the biggest concerns is that ODSP payments are reduced by half the amount of net earnings from work, making it difficult for people to financially benefit from paid employment, particularly if the work is only part-time or at entry level. Other barriers in the design and delivery of social assistance benefits are covered in Section 13.4.c.

c) Police record checks and vulnerable person screening

Horizons Renaissance, among other consultees, reported that systemic barriers to employment were created by having non-criminal contact with police recorded and disclosed as part of a police record check. Police records are created and document mental health information when police take someone to hospital under the *Mental Health Act*. As part of a job applicant's background check, this information can then be released to potential employers, volunteer agencies, or education programs that work with vulnerable clients. Many people reported having been denied job, volunteer and education opportunities because their police background check revealed that they had a mental health disability. We also heard that people who have been apprehended under the *Mental Health Act* have been denied entry into the United States.[102] Police record checks contribute to negative assumptions about mental health issues, because they feed into stereotyped assumptions that people with mental health issues are a risk to the public (CMHA Ontario).

> My husband called an ambulance to take me to the hospital; he was concerned for my welfare and couldn't drive me himself. I went willingly. Now I have an "apprehended under the *Mental Health Act*" on my vulnerable sector screening, with no further explanation. I am currently unemployed; the sector I work in is the non-profit sector and they almost always require a vulnerable sector screening as a condition of employment. In this competitive job market, I believe it's a disadvantage to me to have this on my vulnerable sector screening but my depression almost five years ago in no way makes me a danger to vulnerable clients.
>
> – Survey respondent

In 2011, the Ontario Association of Chiefs of Police (OACP) released guidelines on police record checks that recommend removing references to a person's disability, among other safeguards.[103] The OHRC and other agencies, such as the PPAO, support the new guideline, as it better protects people's privacy and human rights while still promoting community safety.[104] The Ontario Provincial Police has begun to implement the guideline.[105]

Recommendations:

20. The OACP and other agencies should actively promote implementation of the OACP police record check guideline across police services, vulnerable sector agencies and other employers including Government in Ontario.

21. The Mental Health Commission of Canada and the Canadian Association of Chiefs of Police should promote the principles of the OACP police record check guideline with police and vulnerable sector agencies in other Canadian jurisdictions.

22. The Ontario Police College and the OACP should organize training and enhance their existing training on the police record check guideline. The OACP should oversee evaluation of the guideline, with community stakeholders and disability groups. After the guideline is evaluated, the Government of Ontario should consider whether legislative changes are needed to make the guideline more effective.

OHRC commitment:

C15. The OHRC will raise the issue of the disclosure of mental health information that prevents people from entering the United States, with the Canadian Human Rights Commission.

12.2. Taking part in the labour force

a) Hiring processes

There are significant barriers during the hiring and employment process that prevent people with mental health issues and addictions from getting a job. Gaps in employment history due to periods of disability may be hard to explain during the employment process and may create a barrier to being hired. We heard that the employment recruitment process may be set up in a way that disadvantages people with mental health issues or addictions, particularly people who live in poverty. For example, online recruitment processes are out of reach for applicants who do not have access to a computer. As well, job testing and questionnaires may disadvantage people who have cognitive disabilities if accommodation is not supplied.

People told us that during the interview process, employers may make judgements about a job seeker's ability to do the job based on their appearance, which may be affected by the side-effects of medication, symptoms of disability or poverty-related factors. These judgements may contribute to not hiring someone for a job. If people have lost their jobs previously due to disability-related behaviour that was not accommodated, they may not have employment references needed for future positions.

We heard about employment processes that asked questions about people's medical history, including a history of psychiatric treatment, list of hospitalizations and medication, for jobs that did not require them, such as non-safety-sensitive positions. Canadian Auto Workers (CAW) said that it was aware of employers requiring pre-employment drug tests, which it felt was problematic. For more information about the human rights guidelines around this issue, see the OHRC publication *Human Rights at Work, 3rd Edition* (Section 6d).

Several people said that they had to hide their past experience volunteering or working for a consumer/survivor initiative, a mental health agency, in a peer support role, or even gaining vocational experience through a program designed to assist people with mental health issues, because this information could indicate that they have a mental health issue. They feared it would result in denied employment opportunities.

We also heard from employment agencies and several job developers who find employment for people with psychiatric disabilities. The job developers told us that some employers will say that they do not want to work with people with mental health issues, or they hold negative stereotypes about people's ability to work.

The Ontario Public Service – HROntario (OPS) recommended that each organization establish human rights policies and guidelines that comply with the *Code*. To promote hiring free of discrimination, it recommends barrier-free ads, clear and objective selection criteria based on the essential job duties, offering accommodation when requesting interviews and establishing un-biased interview panels trained to be objective when scoring candidates' responses. The OPS said that it is developing tools and resources for managers and staff to reduce negative attitudes about people with mental illness.

b) Disclosing a disability

Both individuals with mental health and addiction disabilities and employers told us that they need clarity on what disability-related information an employer is entitled to know during the application process, and on the job. Many people did not know that they generally do not have to disclose their diagnosis to an employer.

Because of negative stereotypes associated with mental health issues and addictions, many people said they feared disclosing their disability in their employment.[106] Even if they required job-related accommodations, people were reluctant to say they had a disability because they feared discrimination, or their performance being judged on the basis of their disability, instead of their contributions at work. Some people may be concerned that their ability to get disability or life insurance will be affected. For many, these concerns were based on prior experiences of losing jobs or being treated inequitably at work after revealing their disability.

Recent amendments have been made to the *Occupational Health and Safety Act (OHSA)*. The *OHSA*'s workplace harassment and violence prevention provisions lay out the obligation for employers to assess workplace risk. Employers must also warn workers about the threat of violence from individuals that the worker could encounter during the course of their work, including from other workers, if the person has a history of violent behaviour and there is a risk that another worker could experience physical injury. However, employers and supervisors must not disclose more personal information about the risk than is necessary to protect the worker from physical injury.[107]

We heard that the rules around risk assessments and disclosure of personal information about employees may negatively affect people with psychosocial disabilities if they are applied improperly, especially if employees with past, present or perceived mental health issues are assumed incorrectly to be a danger to other workers. In addition, an employee's awareness of the *OHSA* disclosure requirements may create another inadvertent barrier to telling their employer about a psychiatric disability, particularly if they think employers are not appropriately applying the rules. This issue requires further monitoring to make sure that *OHSA* requirements do not have an adverse impact on people with psychiatric disabilities or addictions.

OHRC commitment:

C16. The OHRC and the Ministry of Labour will discuss the impact of disclosure requirements under the *OHSA* on people with mental health issues, and consider how this issue could be monitored and addressed.

c) Inequitable treatment on the job

Some people described their employment experiences positively, telling us about employers that were responsive and respectful of their human rights based on disability. However, others reported how they were treated inequitably at work due to experiencing a psychiatric disability or addiction, which may or may not have been accommodated. We heard repeatedly how people had a change in their job duties or total restructuring of their positions after coming back from a disability-related leave or after their employers found out they had a disability. People reported experiencing demotions, their hours being decreased, changes in job assignments, and dismissal. We heard that employers may assume that people with psychosocial disabilities lack the ability to do their jobs, are unreliable, or cannot handle the stress of the workload, particularly after a disability-related leave.

> Paternalism is the same with people with mental health issues as people with physical disabilities. It comes from good intentions and trying to protect people. The message should be, if you're in management, "how can I help you be successful in the job that you're hired for?", and to use that mindset, as opposed to, "how can I protect you from overwork?"
>
> – Workplace Relations Specialist

Consultees described other types of inequitable treatment that people with psychosocial disabilities may be exposed to at work:

- Being isolated at work after an accommodation (for example, having one's desk moved to another area, or co-workers or managers not speaking with the person anymore)
- Being denied opportunities for training, promotion or privileges afforded to their colleagues
- Being given work that is unchallenging after a disability is known
- Having their contribution at work minimized compared to others'
- Being held to higher standards and penalized for failure.

One roundtable participant in Windsor described going back to work after an episode of illness. Initially, the employer was supportive. However, she said the employer wanted her to sign a contract to say she would be able to attend work consistently for the next month. Due to the immense pressure of the contract, she had another episode and was asked to resign from her job.

The Ontario Nurses' Association (ONA) submitted specific concerns about systemic barriers that exist for nurses with mental health issues. Under the *Health Professions Procedural Code*, the College of Nurses of Ontario can place terms, conditions and limitations on a nurse's certificate regarding their ability to practice if they have a mental health disability. The ONA said that this procedure is not tailored to an individual nurse's circumstances. It said these terms create barriers to employment because employers or potential employers may not be willing to hire nurses or accommodate them to the point of undue hardship once the conditions are known.[108]

OHRC commitment:

C17. The OHRC will approach the College of Nurses of Ontario and any other relevant stakeholders to remove barriers that prevent nurses with mental health disabilities from accessing employment. The OHRC will consider using its mandate, which could include building partnerships, conducting public interest inquiries, intervening in cases, and/or pursuing Commission-initiated applications to address this issue.

d) Harassment and poisoned environment

> My employer supported my attendance at a drug treatment program. I'm now a "recovering" alcoholic with four years of sobriety. However, the director of human resources continues to belittle me with unprofessional remarks and "jokes" about alcoholics. This is totally inappropriate behaviour for someone in a human resources role.
>
> – Survey respondent

Several people talked about being subjected to unwelcome comments or actions at work by managers or co-workers in response to their disability. Comments and conduct raised included inappropriate jokes, questions or references to people's disabilities, medications or accommodation needs, inappropriate disclosure of people's disabilities to other coworkers who did not need to know, or excessive demands for unnecessary medical information. Many said that co-workers made unwelcome remarks, particularly about work that had to be redistributed because of an accommodation. Some people said that they left their jobs because of harassing comments.

> I have endured comments from managers such as being called "cripple" or "people with mental health problems have a screw loose." Managers have targeted me because of my workplace accommodation and have openly discussed my accommodation with my peer group. Members of my peer group are often told that their "less preferable" work assignment is my fault because I am accommodated.
>
> – Survey respondent

> I disclosed my disability to one of my supervisors at a place I volunteered at and she started referring to me as "the one with bi-polar" when talking to other people.
>
> – Survey respondent

We heard that social isolation may also be a form of poisoned environment, where people are repeatedly excluded at work by managers or co-workers. The process can have subtle but very negative consequences. Mental Health Works, which provides training on mental health and employment issues, applies the concept of workplace "mobbing" to people with psychiatric disabilities, and describes how they may be overtly, covertly or even unintentionally ostracised and excluded over a period of time, causing their self-esteem to erode.[109] Mental Health Works described this experience as "long slow, deadly constructive dismissal."

We also heard that employers need more guidance on how to protect the privacy of an employee with a non-evident disability while addressing other co-workers who may react negatively when they are asked to assist with an accommodation. Employers also need information on how to respond in situations where disability-related behaviour causes conflicts in the workplace. The Ontario Public Service said that it requires support from the OHRC to address the discriminatory attitudes of co-workers that the employee is afraid to raise with management.

e) Special employment and special programs

People spoke about both the advantages and disadvantages of special employment supports for people with psychosocial disabilities from a human rights perspective. Special employment support programs exist across the employment sector to address the systemic inequality and historical disadvantage that people with mental health issues and addictions face when finding work, many with funding from the

Ministry of Health and Long-Term Care. These programs target employment for people with mental health issues or addictions. Generally speaking, these employment practices could be protected under human rights legislation as "special programs" or "special employment."[110] Some of these initiatives include:

- *Supported employment:* Programs that help consumer/survivors or people with addictions secure paid employment. People receive flexible and individualized support and training as required on the job.[111]
- *Consumer/survivor initiatives (CSIs):* Self-help groups, alternative businesses or support services run by people diagnosed with mental illness, for people diagnosed with mental illness. There are a large number of funded and unfunded consumer/survivor groups in Ontario, including patient councils and CSIs. They provide a wide variety of supports, both employment-related and non-employment-related, in non-hierarchical settings.[112]
- *Employment equity programs:* Employers may establish their own employment equity programs, to help them increase the representation of people with disabilities (including psychiatric disabilities and addictions) in their workplace.[113]
- *Special employment:* Positions with a core job requirement of lived experience of a mental health issue or an addiction (e.g. an addictions counsellor). One prominent example of special employment is peer support. Peer support is a form of self-help that includes one-to-one relationships between people who have had similar experiences. Like self-help, it is a system of "giving and receiving help founded on key principles of respect, shared responsibility, and mutual agreement of what is helpful."[114] Some peer support workers are unpaid, and some are paid, and work in CSIs or mainstream mental health agencies or hospitals.

These programs or jobs may overlap. For example, many CSIs hire paid or volunteer peer support workers, or may provide supported employment. Many of these initiatives capitalize on the specific expertise and skills that people hold by virtue of having a disability, or having navigated systems that serve people with mental health disabilities or addictions.

> **[Peer support workers] are as important as any other mental health work, yet this best practice is being implemented very rarely. These jobs are important ways that mental health and addictions consumers contribute to a positive consumer perspective in the mental health and addictions systems. It is also a way to be a whole person within these systems as you don't have to hide a part of you. Instead, your lived experience is an essential part of your job. It is a burden to have to hide your lived experience and the special expertise and experience you have to offer.**
>
> – Survey respondent

The Ontario Restaurant Hotel and Motel Association spoke of the positive benefits of supported employment for employers. It said that through a partnership with a job development agency, the Ontario Job Opportunity Information Network, the restaurant, hotel and motel industry has had much success hiring qualified workers with disabilities who have been traditionally denied employment opportunities.

Even though these programs are intended to reduce disadvantage for people with psychiatric disabilities and addictions in the employment sector, we were told that human rights concerns still arise.

We heard that there is far more recognition than in the past of the important roles that peer support workers play in different mental health settings. Many new peer support positions are being created. But there were concerns that peer support workers may be subjected to different terms and conditions of employment than other workers in an organization. Concerns were also raised about the "tokenistic" nature of peer support workers' responsibilities; they may be asked to do work that is not meaningful or does not use their skills, or they do not experience the same level of respect as other workers.

One employment worker said that some community mental health agencies and hospitals post short-term contracts (six months) for peer support positions that are fully funded - something which is not done for other positions. She attributed this to misperceptions that peer support workers, due to having disabilities, are not reliable or dependable. As well, peer support workers may be given limited or the least desirable work hours at an agency, receive little or no training or supervision, or receive training that is unpaid. In some agencies, peer support workers may be paid only an honorarium.[115]

Concerns were also raised that peer support work, supported employment and employment at CSIs tend to be low-paying, part-time, and come with few benefits, compared to other paid positions that are not targeted to people with mental health disabilities or addictions. In a 2009 report on CSIs, the Ontario Federation of Community Mental Health and Addiction Programs noted that some CSIs received less funding for full-time positions compared to other community mental health providers.[116] All of these factors may perpetuate systemic inequality for consumer/survivors and people with addictions by concentrating people in underpaid work.

Some people reported situations where people with psychiatric disabilities and addictions were paid a nominal amount, lower than minimum wage, for activities they did while they were in hospital. These types of programs might be exempt from the *Employment Standards Act* if they are part of a rehabilitation program.[117] People raised questions about the point at which paid work done by consumer/survivors becomes employment that should be subject to the same standards as other work.

Recommendations:

23. The Government of Ontario, the private sector and the non-profit sector should create new opportunities for special employment, supported employment, alternative businesses, employment equity practices and other special employment programs for people with mental health issues and addictions.

24. Organizations that fund special employment or supported employment programs, and organizations that have special employment or use supported employment programs, should review their funding and employment policies and remove any inequities that expose people with psychosocial disabilities to different terms and conditions of employment from those of employees doing comparable work that do not take part in these programs.

25. The Government of Ontario, the private sector and the non-profit sector should review their hiring, promotion, retention, discipline, accommodation and termination policies to remove discriminatory impacts on people with mental health disabilities and addictions to ensure equal opportunity.

f) Workplace stress, mental health and discrimination

A theme that emerged throughout the consultation was the link between stress – either because of workplace bullying, high job demands, or harassment and discrimination based on *Code* grounds – and mental health and discrimination. Stress itself is not considered a disability under the *Code*; however, it is widely accepted that stress can cause or contribute to mental health and addiction disabilities, such as post-traumatic stress disorder.[118]

The Office of the Worker Advisor argued that it is discriminatory that chronic mental stress is excluded from benefit coverage under the *Workplace Safety and Insurance Act, 1997 (WSIA)*. Workers are eligible to receive compensation if workplace factors are a "significant contributing factor" in the development of a physical injury. In the case of mental injuries, a worker's injury must also be "an acute reaction to a sudden and expected traumatic event." A worker is not entitled to benefits for mental stress caused by an employer's decisions or actions relating to the worker's employment, including a decision to change the work to be performed or the working conditions, to discipline the worker or to terminate the employment.[119] A recent decision at Ontario's Workplace Safety and Insurance Appeals Tribunal (WSIAT) expanded the scope of entitlement for traumatic mental stress. A real or implied threat to a person's physical well-being and a diagnosis of post-traumatic stress disorder are not required to find entitlement to traumatic mental stress benefits.[120]

In *Plesner v. British Columbia Hydro and Power Authority*, the British Columbia Court of Appeal found that portions of the BC *Workers Compensation Act*, when combined with the policy on eligibility for compensation for mental stress, were unconstitutional, because it forced workers with purely mental injuries to meet a significantly higher threshold for compensation than was required for workers with work-related injuries that were purely physical in nature.[121] Following this decision, the BC government proposed amendments to its *Workers Compensation Act* which, if passed, will broaden coverage for mental stress conditions arising from significant or ongoing work-related stressors.[122]

Recommendation:

26. The Government of Ontario and the Workplace Safety and Insurance Board should change the *WSIA* and the policy provisions governing workplace insurance benefits to reflect recent legal decisions. They should ensure that there is equality of benefits for people who experience physical disabilities and people who experience mental health disabilities as a result of workplace incidents.

12.3. Employment and the duty to accommodate

a) Creating an inclusive environment

Section 2.4 laid out the duty to design inclusively and remove barriers to participation for people with disabilities. In terms of employment, people described how workplaces are not typically designed to consider the needs of people with mental health or addiction disabilities. For example, although some workplaces have adopted flexible scheduling, we heard that many workplaces are not designed to allow for people who may miss work because of periods of disability. This makes it hard for some people to maintain even part-time work.

As well, people said that many workplaces are designed with the idea that people are able to work long hours under high amounts of stress. This requirement can affect some people with disabilities, including those with psychosocial disabilities. People may find themselves overlooked for promotion if they cannot meet expectations to work long hours in highly stressful work, or need performance standards to be modified as a form of accommodation. At the same time, employers are entitled to productive employees and to develop standards and targets that meet their organization's objectives.

We also heard that people with psychiatric disabilities or addictions can have different ways of completing the work that may not fit mainstream work practices. One consultant on mental health and employment said that jobs need to be designed for people's skills and how they best do the work to maximize people's contributions. To achieve true equality for people with disabilities, we heard that flexibility in work arrangements and standards needs to be built into employment opportunities and expectations.

> The OHRC heard that in many workplaces, drinking alcohol is a big part of the work culture. Such a culture may create automatic barriers to people with addictions who may be in recovery, especially when drinking with colleagues, superiors or clients helps to advance a person's career.

The organizational culture of many workplaces was also seen as excluding people with mental health issues and addictions. In general, both employers and employees told us that there is a high degree of discomfort and confusion talking about mental health issues at work. Some said that the lack of dialogue about mental health issues in the workplace contributes to an unwelcoming environment, and to perceiving people who have mental health issues in a negative light. This in turn contributes to barriers in the recruitment or retention process, and to not adequately responding to issues of harassment or hostile treatment.

b) Accommodating individual needs in employment

People repeatedly raised concerns about their own experiences, or the experiences of other people with mental health disabilities and addictions, who received inappropriate or no accommodation in the workplace. This is happening even though it is more and more common for workplaces to have disability accommodation policies, provide disability benefits, work with third-party disability agencies to return employees to work after disability leaves, and involve unions in the accommodation process. Employers acknowledged the duty to accommodate employees with psychosocial disabilities, but said that this can sometimes be challenging when trying to meet the needs of the business. One employer said that its managers may not be consistently implementing workplace policies with employees with mental health issues or addictions compared to other employees.

The types of accommodations required by employees with psychosocial disabilities, depending on individual circumstances, could include:

- Flexible working hours
- Longer training periods
- Supports such as job coaching
- Adjustments to the ways information is communicated
- Short- or long-term leaves of absence
- Job sharing arrangements
- Modified production standards.

Both Mental Health Works and the Great West Life Centre for Mental Health in the Workplace provide a list of the most common types of accommodations on their websites.[123] Employers say that they found using extended support systems (such as employee assistance programs or "EAPs") beneficial for employees who need support.

The CAW was concerned that employers rush too quickly to assist a worker with disability benefits, without considering whether they could be accommodated and can perform the essential duties of the job. Such actions can have negative effects on workers. The Human Rights Legal Support Centre (HRLSC) also said that some claimants have alleged they have been denied long term disability insurance because they can do the work if accommodated, even though the accommodation is being denied by the employer. In other situations, employers use the denial of insurance benefits as a reason to deny that accommodation is required.

c) Privacy, autonomy and the duty to accommodate

The privacy of employees' medical information was a concern for many (see section 10.1.for more information). Sometimes requests for information move beyond privacy into a person's right to self-determination and to control their own care. We heard that there is a trend in human rights claims that allege that third-party disability companies expect to be informed of employees' full diagnoses, prognoses and treatment plans, and want ongoing verification that people are "medication compliant" (HRLSC). Some employers may want the employee to agree to certain conditions to receive accommodation. These may be seen as intrusive, such as seeing a psychiatrist versus a psychologist for assessment or treatment (HRLSC), or adhering to a certain treatment plan.

d) Performance management, discipline and termination

Organizations and individuals described how employees with mental health disabilities and addictions who need accommodation may instead face discipline or lose their jobs. We heard of situations where employees with mental health issues or addictions were subjected to performance management after coming back from medical leave.

In some cases, people with mental health and addiction disabilities may exhibit behaviour linked to their disability that affects their performance at work, and they are disciplined or dismissed because of it. Employers reported that these situations can be difficult to manage, even if workplace accommodation procedures exist. They told us that employees may not want to disclose a disability even if employers are willing to accommodate. Consultees emphasized that employers have a duty to inquire and offer accommodation if they suspect that discipline may be related to a disability, especially when employees themselves may be unable to identify their needs or may fear being stigmatized if they disclose.

> Workers with addiction disorders frequently face discipline, including suspension and discharge, as employers attempt to deal with issues which manifest in the workplace and which arise as a result of these disabilities. Absenteeism, productivity, insubordination and an inability to interact with colleagues are frequently cited grounds for the imposition of discipline in relation to workers living with addiction. All of these behaviours are viewed as culpable misconduct deserving of discipline, but little thought is given to the underlying addiction which is fuelling the conduct.
>
> – CAW

In addition, the CAW and others said that "last chance agreements," in which a worker is to remain free of alcohol or drugs for a prescribed period, are problematic. A breach of the agreement generally leads to the immediate termination of employment. These agreements are subject to the duty to accommodate.[124]

We heard that employers may be reluctant to discuss performance issues or address conflicts when they feel mental health may be a factor. The result is that problems tend to build to a crisis before the needs of employees with mental disabilities are addressed.

Recommendations:

27. All employers should develop human rights policies and procedures outlining their organization's obligations under the *Human Rights Code*, including the duty to accommodate people with psychosocial disabilities to the point of undue hardship. Employers should ensure their human rights policies identify that people with mental health issues and addictions are protected under the ground of disability, and eliminate systemic barriers in the workplace (such as in their organizational culture) that may exclude or disadvantage people with mental health issues and addictions.

28. All employers should train their employees and managers on their responsibilities under the *Code* regarding the human rights issues that affect people with mental health disabilities and addictions. This training should address preventing and responding to discrimination and harassment, systemic issues affecting people with psychosocial disabilities and the duty to accommodate.

OHRC commitment:

C18. The OHRC will continue to provide education on human rights and the workplace to employers, employees and unions, and will include a focus on human rights, mental health and addictions.

13. Services

Under the *Code*, service providers have a duty to provide services that are free from discrimination and harassment. "Services" is a very broad category and includes services designed for everyone (shops, restaurants or education), as well as those that apply specifically to people with mental health disabilities and addictions (the mental health system or addiction treatment centres). Some people have limited involvement with certain services; however, many play a critical role in people being able to enjoy their rights, livelihood, health, access to justice, or ability to take part in community or political life. The types of services most identified in the consultation as posing concerns were education, the criminal justice system (including policing, courts and the correctional system), social assistance programs, health and mental health care, child welfare, government rules regarding driver's licences, the insurance system and administrative tribunals.

13.1. Availability of mental health and support services

A large number of participants in the consultation told us about the pressing need for adequate mental health and other support services for people with mental health issues and addictions. We heard about the profound impact that the lack of appropriate mental health services has on people's lives – including increased criminalization, increased homelessness, perpetuation of poverty, increased social isolation, deteriorating physical and mental health, and premature death. We also heard that the lack of available services in the community has an impact on people's ability to exercise their human rights in other areas. For example, long wait times for psychological assessments to identify someone's needs can delay accommodation in employment, education or in the criminal justice system, which may result in the denial of equal access or opportunity in these areas.

The themes raised in this consultation reflect, in part, what people raised in the provincial and federal consultations on reform of the mental health system.[125] For example, we heard about the need for more mental health and addictions treatment, counselling and support services (such as housing and employment support). People described how these types of services were often not available for people released from psychiatric and correctional institutions and people who are in correctional facilities. We also heard that specific *Code*-protected populations have a great deal of difficulty accessing services: youth, Aboriginal Peoples, refugees and immigrants, people with learning or developmental disabilities, women who have experienced violence, people with hearing disabilities, people with borderline personality disorder, people with fetal alcohol spectrum disorder and people in the Francophone community. Where people are from two or more of these communities, we heard that services are that much more difficult to find or access.

We also heard concerns about differences in funding for services in rural communities versus urban centres in Ontario, the very long wait-lists for mental health professionals, the lack of Ontario Health Insurance Program (OHIP) coverage for medications and mental health counsellors such as psychologists or other therapists. People said that it was a problem that to get inpatient treatment at a hospital, they had to be at the point of a state of crisis, or assessed as a danger to themselves or others under the *Mental Health Act*.

Uncoordinated service delivery and the narrow mandates of mental health services, other services and the government ministries funding these services were seen as creating a problematic "patchwork" of services, leading to people being turned away as ineligible. For example, one person in Ottawa said that eligibility for people with a dual diagnosis is defined differently across services funded by the Ministry of Health and Long-Term Care and the Ministry of Community and Social Services.[126] The Learning Disorders Association of Ontario told us that lack of coordination of services within and across governments is a big problem for people with learning disabilities who also have mental health disabilities.

> **I find sometimes that mental health services can be very specific – if you do not fit in the category for what you need help with, then you fall through their cracks and lose the help you need.**
>
> – Participant in North Bay roundtable session

We heard concerns that the mental health system is funded inequitably compared to general health care. Past reports have documented the discrepancies between the mental health system and the broader health care sector.[127] The 2002 Romanow report on the state of Canada's health care system identified how the mental health system has been traditionally seen as one of the "orphan children" of health care, because mental health and addictions programs have been managed separately from other health care programs.[128] Canada spends less public health care funding on mental health than most developed countries.[129] To correct imbalances in funding of general and mental health care, the Mental Health Commission of Canada's national mental health strategy recommends increased investments in mental health care and other social spending (such as housing, education, and the criminal justice system).[130] Others have suggested merging mental and general health systems, so the whole person is treated.

The Supreme Court of Canada has given governments deference to allocate scarce resources and choose the services they fund. However, they must do so in a way that does not discriminate.[131] If its allocation of health care resources has an adverse effect on any *Code*-protected group, the government may be required to show their decision is reasonable and legitimate (*bona fide*) in the circumstances. This includes considering the objectivity of the process that was used to make the decision. It also includes considering whether the decision on health care coverage was affected by discriminatory views about the group in question.[132]

Where there is a lack of access to appropriate services for people with mental health disabilities and addictions, this may also conflict with rights under the *Convention on the Rights of Persons with Disabilities (CRPD)*. The *CRPD* says that States Parties (including Canada) shall provide health services needed by persons with disabilities specifically because of their disabilities, including early identification and intervention as appropriate (Article 25 b); and that States Parties shall organize, strengthen and extend comprehensive habilitation and rehabilitation services and programs, particularly in the areas of health, employment, education and social services (Article 26 (1)).

Most people said more mental health and other support services are needed that address people's diverse needs and use a variety of approaches. It is not within the OHRC's role or expertise to make recommendations on how funding should be allocated to various mental health, addiction and other support services. However, any inequities in the availability of these services should not contribute to people with mental health issues or addictions experiencing barriers to accessing appropriate health care and other supports compared to people with other types of disabilities or people without disabilities.

Recommendation:

29. The Government of Ontario should look for and correct inequities in health care, rehabilitative and support services for people with mental health disabilities or addictions compared to general health care.

13.2. The duty to accommodate in services

An overview of the duty to accommodate is outlined in section 2.4. We also heard the following.

a) Inclusive and accessible services

Many consultees described how different kinds of services, including income support, policing and mental health support services, generally are not designed to meet the needs of people with mental health issues or addictions. Attitudinal barriers may exist that disadvantage people with mental health issues and addictions. The Ontario Association of Social Workers (OASW) told us that discrimination can be built into the design of the service where there are limited resources, poor accountability mechanisms, and a lack of specific mandates, training and capacity to work with clients who are thought of as "difficult to serve" and more complex situations.

Consultation participants said that services are often not designed to address the needs of people with episodic disabilities. When the service is ready, the person may not be, and vice versa. Due to funding restrictions, service organizations may have mandates to provide services only to people with severe disabilities. People may be pressed to show that they meet the criteria for being considered permanently disabled, instead of being significantly affected by their disability (University of Guelph Human Rights Office). People related being denied benefits or services because, at the time they were assessed, some of their conditions were not disabling.

Throughout the consultation, we heard that services are built on the assumption that people have just one disability. People with multiple disabilities find it difficult to access some services because the services are not inclusively designed. Many told us that having a concurrent intellectual disability, addiction or learning disability can create a barrier to receiving mental health treatment or support services. Some services may be designed to only serve people with physical or other disabilities, and exclude people with psychosocial disabilities when they could also benefit from the service.

Services may inadvertently create barriers for people with psychiatric and addiction disabilities through their design, structures, policies or decision-making processes. The OASW, among others, said that many mental health and support systems have referral processes that symptoms of mental illness can make very difficult. Some consumer/survivors or people with addictions may struggle with organizing their thoughts, which can interfere with the need for continual monitoring of waitlists.

Application forms for certain services (such as administrative tribunals or ODSP) were described as complex and difficult to navigate, not written in plain-language, or requiring multiple types of documentation, which may cost money that people do not have. Call centres that provide initial assessments, such as for social assistance, or at Legal Aid Ontario, were said to be difficult to access. For people with cognitive or memory impairments, low levels of literacy, or lack of access to a telephone, application processes can be extremely difficult. See section 11.1.b. for the issues raised about the application process for supportive housing.

Certain payment or evaluation methods may unintentionally encourage service providers to turn away people with mental health issues and addictions. Where service providers are compensated per client, or are evaluated based on service targets that aim for a high number of customers served (for example, doctors' offices), this can adversely affect people with mental health disabilities and addictions and other types of disabilities who may need more time (CMHA Ontario; ARCH). Also, we heard that people with psychosocial disabilities may be perceived to be "difficult" when they need more time from service providers. Allowing a client to take more time due to disability-related needs is part of the duty to accommodate. Service providers said that offering more time to clients who need it can require a balancing when considering other clients who also need the service.

> **ARCH described how lawyers taking legal aid certificates may be discouraged from serving clients who may lack capacity but do not attend with a substitute decision-maker. It takes time to assess capacity at each meeting with someone, which lawyers may not be compensated for.**

Similar to rental housing, people with psychosocial disabilities may be screened out of or denied services altogether because of factors related to their disability. In particular, we heard that service users with psychiatric disabilities may be denied services because they are seen as too "high risk" due to past disability-related behaviour that was problematic in that service or other services. People were also concerned that many services do not consider their duty to accommodate and simply bar people with a criminal history from taking part, even if the criminal history is related to a mental health issue or addiction.

As well, some people told us that people may be turned away by service providers if a person is deemed "non-compliant," doesn't behave in a way the service provider expects, or does not accept a certain type of mental health treatment where this is not a legitimate or *bona fide* aspect of taking part in a service. For example, one person at a university described being denied alternative testing arrangements that were required to accommodate their disability, because they did not see their counsellor regularly.

> **Some people told the OHRC that if they did not comply with taking the medication prescribed by their psychiatrist or doctor, they were told they would not be able to continue seeing them.**

We heard that to properly consider the needs of people with psychosocial disabilities, services should be designed with time and flexibility in mind for everyone, taking into account everyone's individual needs, without having to ask or assume that someone has a disability. Consultees identified that an organization's rules, policies and procedures must be modified and made flexible to meet individual needs. In redesigning services or systems, participants in the Ottawa roundtable sessions were particularly vocal about the need for consumer/survivors to be included at the table to guide policy direction, quoting "nothing about us, without us."

The types of accommodations that might be required in a service environment for someone with a psychosocial disability include:

- Flexible deadlines, or extra time given
- A quiet service environment
- Extra support from people (human support)
- Multiple ways of contacting the organization (for example, telephone, email, in-person, mail)
- Facilitating or providing support for decision-making
- Intake forms or other forms of written communication that are accessible and written in plain language
- Flexibility in scheduling appointments
- Considering disability as a mitigating factor before imposing punitive measures.

Recommendation:

30. In accordance with the *AODA* and the *Code*, service organizations should review their policies, practices, application forms and decision-making procedures, working with consumer/survivor groups and accessibility experts to identify and eliminate barriers that may result in inequitable treatment for people with psychosocial disabilities or addictions.

13.3. Inequitable treatment and harassment in services

Many service providers understand their individual obligations to treat people equitably under the *Code*, with some consultees describing very good interactions with service providers where they felt respected, valued and included. Hundreds of individual service providers and organizations came forward to raise their concerns about human rights violations against people with mental health and addiction issues. As one service provider, a regional director of a health care centre said, "…we are always heavily involved in these issues because we feel clients are discriminated against."

However, many noted that, compared to other people, people with mental health disabilities and addictions may experience unprofessional behaviour or inequitable treatment from service providers, including comments or behaviours based on disability that could amount to harassment or a poisoned service environment. They also talked about judgements on the part of service providers that clients with mental health issues or addictions are trying to "take advantage" of systems.

These comments or behaviours may arise from negative or discriminatory attitudes towards people with psychosocial disabilities. The Ontario Association of Social Workers told us that service providers may use "common language that is discriminatory, judgmental, and derogatory, which can impact on a potential service user's willingness to access service. Service providers may not see past the label assigned to a consumer-survivor, minimizing a person's identity outside of the illness."

> After surgery, my surgeon told me, "Had I known you were crazy, I wouldn't have operated on you."
> – Focus group participant

We heard particular concerns about mental health and primary health care professionals creating an unwelcoming, harassing or poisoned service environment for people with mental health issues or addictions.

> I worked in emergency services [as a paramedic] and they are very degrading towards mentally ill people. At lunch they would talk about having to go pick up another "crazy" or "junkie" and these are the people on the front line.
> – Participant in North Bay roundtable session (who also identified as a consumer/survivor)

In part because these same concerns were raised in the Kirby report, the Mental Health Commission of Canada has directed the first stage of their nationwide anti-stigma campaign towards health care professionals.[133]

One example of the impact of labelling came from two people who told us that they were given a purple armband to wear in hospital to identify that they were a danger to themselves or others (both were suicidal). They spoke of feeling very stigmatized and one stated that she was treated worse by staff when she was wearing the armband than when she was treated in hospital and was not made to wear one.

Consultation participants raised concerns about privacy. Many said that information about a person's mental health and addiction history can be shared from one service provider to another, often after a client signs a "blanket release" years earlier. Consent forms may not be regularly renewed. This issue may result in service providers knowing more private medical information than they need to provide the service, and potentially breaching service users' privacy.

13.4. Types of services that raised concerns

a) Education

> Article 24 of the United Nations' *Convention on the Rights of Persons with Disabilities* provides for the right to education. By ratifying the CRPD, Canada has committed to taking progressive steps to ensure that students with disabilities are not excluded from the education system based on disability; that accommodation is provided in the education system; and that effective individualized support measures are provided to maximize academic and social development consistent with the goal of inclusion.[134]

Mental health issues will often start to appear when people are of school age, either in post-secondary school or secondary school, or in elementary school. Consultees said that initially assessing and identifying students' needs are critically important. In Windsor, concerns were raised that students may be assumed to be "lazy" or "trouble-makers" when they have emerging mental health issues that aren't understood or taken into account. At all levels of education, particular accommodations may be needed to make sure that students have equitable access to education. Common forms of accommodation that may be needed by students with mental health issues include alternative methods of testing, human support, extensions for assignments, consideration for time missed to address a disability, and consideration around academic suspension if it is related to disability.

Elementary and secondary school

ARCH told us that attitudinal barriers are common in Ontario's public education system. These stereotypes, assumptions and discriminatory attitudes pose major barriers and may prevent students with mental health disabilities from receiving appropriate accommodations. We heard that students with mental health issues may be viewed as not having the capacity to excel. These types of assumptions may be more likely to occur when people also face racial discrimination or discrimination based on other *Code* grounds. Participants in the focus group hosted by the Ethno-Racial Disability Coalition of Ontario said that racialized students, with parents who have mental illness or addictions, may be targeted at school and streamed into programs that are below their educational capacity.

Some consultation participants described being treated poorly, bullied or shunned by other students based on a psychosocial disability, or being perceived to be "different," leading them to feel excluded.

> **Being ostracized at school for acting funny or being different is still the norm – and if one chooses to disclose, no one knows enough about mental health issues not to shrug it off or laugh. More education at all school levels is needed, not just about the physical disabilities but the mental ones.**
>
> – Survey respondent

The lack of appropriate treatment or assessment services results in students' education being interrupted. We heard that students can wait up to two years for psychological assessments to identify their needs. The OSSTF/FEESO said that, due to the lack of proper resources to assess and treat such students, the education system may need to deny access to schools to students who present a threat, either to themselves or others. In its *Guidelines on Accessible Education*, the OHRC said that although there may be situations where a student poses a health and safety risk to him or herself or to others, the accommodation process must still be fully explored, to the point of undue hardship.

Several consultees, including ARCH, were concerned that students with multiple disabilities, including behavioural, intellectual and developmental disabilities such as autism or ADD/ADHD are suspended or expelled from schools due to disability-related behaviours, without appropriately considering accommodation. We have recognized this for many years, and included it in our consultation on accessible education, reported in *The Opportunity to Succeed*. ARCH said that multiple suspensions and/or poor school performance due to lack of appropriate disability accommodations have very negative impacts on students' mental health. Parents and students have reported to ARCH that students who are frequently suspended and/or not accommodated in school develop anxiety disorders, depression and low self-confidence. The OSSTF/FEESO noted that students with untreated school phobias, undiagnosed depression or psychosis may be unable or unwilling to attend school regularly. The Lakehead District School Board's Special Education Advisory Committee recommended that resources be provided to school boards to ensure appropriate training to staff and students to address any issues that may arise around students' needs.

> **The school board said mental health is not their concern, right after another special needs boy killed himself last year. I was supposed to get occupational therapy last year and they did not bother to put the request through so I could get help. No one at the school even read my file so I could get the right help to learn at school. They even passed me and I never finished my work or wrote my exams. It is easier to suspend the students rather than help us. If we do something a little bad they call the police without calling our parents to speak up for us. My mom says this is a way to just scare us.**
>
> – Survey respondent

We have heard concerns that students with disabilities, including mental health issues, are sometimes placed in special education classes without their parents' consent, with few opportunities for inclusion with regular classes. This is inconsistent with the human rights principle of inclusion, the OHRC's *Guidelines on Accessible Education*, the Ministry of Education's policy position, and the direction of Regulation 181/98 of the *Education Act*, which governs the placement of exceptional pupils in classroom settings.[135]

Consultees pointed to the Ministry of Education's Inclusive Education strategy as providing a positive foundation for respecting the human rights of students with disabilities. The strategy and Policy and Program Memorandum 119 (PPM 119) recognize that discriminatory barriers to learning may affect students based on mental disability, as well as other *Code* grounds. PPM 119 lays out requirements for all publicly-funded school boards to develop, implement and monitor an equity and inclusive education policy, designed to foster a positive school climate that is free from discriminatory or harassing behaviour.[136]

As well, the first three years of the Ministry of Health and Long-Term Care's (MOHLTC) 10-year Mental Health Strategy have a particular focus on children and youth. The MOHLTC has said it will invest in increasing the number of mental health resources (including mental health workers) in schools, promote mental health literacy in schools, and promote anti-stigma practices for children, youth and educators, among other groups.[137]

Post-secondary school

Submissions about post-secondary education focused on the duty of post-secondary institutions to accommodate students with psychiatric disabilities to the point of undue hardship, either when applying for school or during students' school careers. Several people said that, because of disability offices that help post-secondary students with disabilities to get accommodation, they received accommodations without difficulty. However, others told us that there were still gaps in accommodation practices, making students with psychiatric disabilities more likely to drop out.

> **Despite being in my school's disability program that allows me to have some accommodations, I sometimes run into professors that are not willing to give me the accommodations I need. I think because I don't have a visible disability many people think I'm faking it. It's so much work to fight for my accommodations that I usually end up dropping the course and that puts me even farther behind in school.**
>
> – Survey respondent

We also heard that students with psychosocial disabilities are sometimes questioned about gaps in their employment history or education, which prevents them from being considered for post-secondary school programs. These gaps may be related to time taken to recover from mental health or addictions issues (ARCH). As well, we heard how accommodation requests may be contested by professors or others, and how a diagnosis or detailed information about a disability was required for accommodation purposes, which was seen as compromising students' privacy.

As in elementary and secondary schools, people said that delays in mental health services (e.g. getting a psychiatrist's appointment) result in decreased access to education for students with psychiatric disabilities and addictions, because schools rely on these practitioners to verify students' accommodation requests. The University of Guelph's Human Rights Office pointed to the need for educators to consider the fluctuating nature of a person's mental health issue when considering accommodation planning. It added that requests for academic consideration must be evaluated on a case-by-case basis, and the need for accommodation must be balanced with the institution's need for academic integrity.

The OHRC heard that professors discourage some students with mental health histories from doing co-op or educational learning placements in settings where they would be working with people or working in the mental health field. This has an impact on their future careers. In addition, the requirement of police records checks (see section 12, Employment for more details) has had an impact on people's ability to find co-op or field placement positions working with vulnerable sectors.

> I was denied admission to a medical laboratory science program. The program required a police records check because I would have had contact with patients to draw blood. Due to two incidents where I was taken to the hospital by police because of suicidal ideation, I was denied entry to the program.
>
> – Survey respondent

b) Presumption of risk: Driver's licences, child protection and insurance

> I once had a Children's Aid Society worker tell me, "But you're bipolar. How can you parent?" This same worker admitted she did not believe parents with mental illness could parent.
>
> – Survey respondent

Many people said the services of child protection, life and disability insurance, and rules around driver's licence suspension were potentially problematic from a human rights perspective. In particular, people were concerned that they were denied equality in these services because they were presumed to pose a risk based on disability.

The Psychiatric Patient Advocacy Office and other consultees raised concerns that the system of suspending driver's licenses based on a mental health condition or drug or alcohol addiction under the *Highway Traffic Act* is done without a proper individualized assessment of that person's medical condition by doctors or the Ministry of Transportation. We heard that the appeal process to get a driver's licence back has disproportionate effects on people with mental health disabilities and addictions, because of its complexity and expense.

We heard issues about the child welfare system. People with mental health issues and addictions were sometimes presumed to be a risk to their children based on disability-related stereotypes. We were told that parents have been reported to the Children's Aid Society after disclosing a mental health issue to a child's school. We also heard concerns that addictions testing may not properly assess a person's risk to their children.

Many people said they had difficulty getting life or disability insurance, including individual and group insurance, because of a psychosocial disability or addiction, and the associated risk with suicide or impairment. They also told us they were deemed ineligible to receive insurance because they had "pre-existing conditions," even though they were not currently unwell.

The Human Rights Legal Support Centre said that one of the conditions of insurance may be that someone is expected to be free from any disability-related symptoms or cannot have received treatment in the last 12 months. However, this may have a negative impact on someone with a mental health disability because the person is penalized even if the treatment is helping to keep them well. The Canadian Life and Health Insurance Association said that insurers assess a person's risk based on factors such as the severity of the condition, whether it has been chronic or recurrent, the record of care by the attending physician, and the time elapsed since the most recent incident or onset of symptoms.

Where distinctions in these sectors are based on disability and they create a disadvantage, this may amount to discrimination. Defences and exceptions under the *Code* may apply in these situations and also need to be considered. Organizations must make sure that risk assessments are made on a case-by-case basis, and are based on objective criteria.

OHRC commitment:

C19. The OHRC will examine further the policies or processes of driver's licence suspension, child protection or insurance policies and consult with the appropriate government ministries and stakeholders to consider whether these contravene the *Code*. Where these practices have the potential to violate the *Code*, the OHRC will address these concerns using the functions in its mandate.

c) Public assistance

> It is an unkind system that makes clients feel that once they are "on disability" that that is it – that is their life, their life of perpetual poverty and uselessness. How is that economically sound practice? How is underutilizing human resources smart business or remotely good for the overall prosperity of our province or country?
>
> – Written submission

Concerns raised about the experience of receiving public assistance made up a significant portion of the consultation. We heard about barriers in designing and delivering these programs that cause disadvantage to people with psychosocial disabilities. As identified in the section on socio-economic status, OW and ODSP are currently being reviewed in Ontario, with a view to removing barriers and increasing opportunities for people to work.

We heard concerns about the application processes for social assistance (OW and ODSP). In addition to the forms being complex, many said it can be very difficult to get all the required information together in the specified time, especially when dealing with symptoms of a disability. This can cause some people to be cut off from benefits or not accepted.

We heard that the "emotional energy" needed to navigate the social assistance system compounded with mental health symptoms was often too much; some described just "giving up." As a result, people lost out on basic needs such as food, paying rent or paying for utilities. As well, people described how dealing with the stresses of the system had negative impacts on their mental health. One social assistance representative told the OHRC that efforts have been made to increase the accessibility of the service by improving letters and brochures and making case workers more available.

Navigating the system seemed impossible. I wasn't thinking clearly [after being released from hospital]. You're on your own. There is a system there but accessing it is almost impossible.
– Participant in Toronto roundtable session

We also heard concerns about the types of benefits that people required due to disability but these were not available through social assistance. People described how ODSP would not cover certain extra medical expenses related to disability, such as a special diet required for a mental health issue or addiction. The OHRC is involved in ongoing litigation at the Human Rights Tribunal of Ontario challenging aspects of the Special Diet Program provided under ODSP (and OW). The litigation may consider the exclusion from special diet benefits of people with schizophrenia who are taking certain types of medication.

Many people said that service providers did not take into account their individual disability-related needs. Appointments may be made at points of the day where people cannot attend, due to disability-related symptoms. Some said that difficulty with memory and difficulty concentrating or in expressing oneself due to a disability can make it difficult for people to "state their case" to a caseworker, resulting in delays in receiving services. We also heard how negative attitudes on the part of workers towards service users were common, and many people felt they were treated as if they were "taking advantage" of the system.

Strict conditions or complex procedures for reapplying for public assistance may create barriers for people with mental health issues and other episodic disabilities by making it difficult to access the system repeatedly. In the case of OSAP, the University of Guelph's Human Rights Office notes that students may have to withdraw from semesters due to disability, and they may be placed on OSAP restriction. They are limited to one life-time appeal of this restriction, which may be difficult due to the unpredictable nature of their mental health issue or addiction.

Other concerns were raised about Ontario Works and ODSP in relation to people with addictions. After the decisions in *Tranchemontagne*, the Government of Ontario started to allow people whose sole disability was an addiction to be eligible for ODSP. However, even with a doctor's determination that a person's addiction constitutes a disability, ARCH said that it can be very difficult to be accepted as eligible for ODSP, and applicants often have to go through the appeal process to dispute their rejection. Others expressed concerns that people with addictions are subject to greater monitoring than other people receiving OW benefits, and that if a person misses attending their mandated addiction program due to relapse, benefits will eventually be pulled.[138]

Recommendation:

31. The Commission for the Review of Social Assistance in Ontario should look at inaccessibility of the social assistance system for people with mental health issues and addictions, and make sure social assistance policies and practices do not have a negative impact on people identified by *Human Rights Code* grounds, including mental health and addictions.

d) Health care

Article 25 of the *Convention on the Rights of Persons with Disabilities* says that persons with disabilities have the right to enjoy the highest attainable standard of health without discrimination based on disability. This includes:

- Providing people with disabilities the same range, quality and standard of health care programs as provided to other people
- Providing health care services that are needed by people with disabilities specifically because of their disabilities
- Requiring that health care professionals provide the same quality of care to people with disabilities as to others, including on the basis of free and informed consent by, among other thinxgs, raising awareness of the human rights, dignity, autonomy and needs of persons with disabilities through training and disseminating ethical standards for public and private health care
- Preventing discriminatory denial of health care based on disability.[139]

Primary health care

People with disabilities have the right to health care under international human rights law – and they have the right under the *Code* and the *CRPD* to be treated without discrimination when they receive health care. A large number of people made submissions about their experiences, or the experiences of people they knew with addictions or mental health disabilities, with the primary health care system, including emergency rooms, family doctors and other health care professionals.

CAMH and CMHA Ontario said a systemic issue is that people with mental health issues and addictions are less likely to receive primary health care in general, or have the same access to in-patient hospitalization.[140] People with mental health issues also reported waiting a very long time for help in emergency rooms because they may not be seen as "emergency" patients compared to people with other kinds of ailments.[141]

Another major concern was that people's physical symptoms were not believed if service providers were aware that they also had a mental health issue or addiction. This may lead to people being misdiagnosed and to delays in treatment, their physical symptoms being inappropriately dealt with, or not being assessed at all. As a result, people related hiding their mental health issue, medications or addictions from their doctors because of fears that their physical symptoms would not be taken seriously, or they would be refused service.

We also heard that people are often assumed to be "drug seeking" when they require medical care for severe physical symptoms (PPAO).[142] One person described going to the hospital for severe abdominal pain. When the doctors found out that the person received methadone replacement therapy, the person was left alone in hospital for 10 hours, even after fainting from the pain. Doctors later determined the person needed intestinal surgery. The Psychiatric Patient Advocacy Office (PPAO) said that clear policies and procedures are needed or else the stigma associated with psychiatric issues, including a disproportionate emphasis on public safety and security, will overshadow non-psychiatric problems and create barriers to primary care.

A notable theme was that many physicians, even general practitioners, refuse to treat people with psychosocial disabilities, often because their needs are seen as "too complex."

> I was desperate for a doctor and when I filled out the form she said that she did not accept patients who have a mental illness. I had to beg her and promise I would just come for a yearly physical to get my birth control pills. I never go to her except once a year. I use the walk in clinic and Urgent Care as well as Telehealth.
>
> – Survey respondent

We heard about the reluctance of some doctors to work with people with certain mental health disabilities or addictions, and that people with eating disorders, bipolar disorder and borderline personality disorder were turned away by general practitioners and mental health professionals, including psychiatrists, based on disability. We heard that some doctors may not want to take on patients who have a history of addiction because of negative stereotypes about people with addictions. Doctors may also lack the training to address these needs.

Concerns about service refusal have been documented in the Kirby report and in the Ministry of Health and Long-Term Care's province-wide mental health consultation. Contributing to this problem may be funding models that may promote seeing patients as quickly as possible and seeing healthy patients. As a result of its own provincial consultations on mental health, the all-party Select Committee on Mental Health and Addictions recommended that, "The MOHLTC should examine further changes to the family physician remuneration model to focus on improving access to and the quality of primary care for people with mental illnesses and addictions."[143]

In its policy on accepting new patients, developed with input from the OHRC, the College of Physicians and Surgeons of Ontario (CPSO) states that patients should be accepted on a first-come, first-served basis. Scope and clinical competence are grounds for limiting patients' entry into a practice. However, these grounds must not be used as a means of unfairly refusing patients who are perceived to have complex health care needs or to be "difficult."[144]

Recommendations:

32. The College of Physicians and Surgeons (CPSO), the Ministry of Health and Long-Term Care, should consult with the OHRC and disability groups, to increase compliance with the CPSO's policy on accepting new patients.

33. The College of Physicians and Surgeons of Ontario should review its complaint policies and procedures and eliminate barriers that may make it difficult for people with mental health and addiction issues to complain about poor professional practices.

34. The College of Physicians and Surgeons of Ontario, the Ontario Medical Association, the Ontario Hospital Association and the Ministry of Health and Long-Term Care should train doctors and medical students about their obligations under the *Code* to not deny service to people based on *Code* grounds.

OHRC commitments:

C20. The OHRC will be available to consult with the College of Physicians and Surgeons and the Ministry of Health and Long-Term Care on increasing compliance with the CPSO's policy on accepting new patients.

C21. The OHRC, where appropriate, will use its mandate to launch public interest inquiries, seek to intervene in cases, and/or launch Commission-initiated applications to actively challenge cases where doctors allegedly deny service delivery to people based on mental health or addiction disabilities.

Mental health care

Some consultation participants related their positive experiences within the mental health system, describing it as "life saving," and reported how they were treated with respect by supportive empowering doctors and staff. However, many others reported negative experiences, specifically with the hospital system, noting concerns about labelling patients, over-relying on medication, depriving them of liberty and inappropriately using restraints. Some representatives of psychiatric institutions said that in understanding the concerns that were raised about the psychiatric system, we must consider the provisions in the *Mental Health Act* and other guiding legislation, which allow for restricting people's rights in certain circumstances. In Ontario, people with a mental disorder can be institutionalized against their will if they are a danger to themselves, other people, or may unintentionally injure themselves, or if the person's condition is deteriorating and they require hospitalization.[145] Some service providers said it is a challenge to balance potentially conflicting health and safety concerns for individuals and the community, with the individual's rights.

Some consultees were concerned about their family members being turned away from involuntary admission into hospital because they did not meet the criteria under the *Mental Health Act*. Some people said that they were prevented from learning about family members' medical information without the person's consent. The Ministry of Health and Long-Term Care has agreed to set up a task force to determine if existing mental health and privacy laws need to be changed to take these concerns into account.

- **International concerns about mental health institutions:**

  In Ontario, there are several safeguards embedded in legislation and institutional policies to protect against the ill-treatment and abuse of people with psychiatric disabilities and addictions. These include methods of appeal of involuntary admission to hospital and other consent and capacity issues, providing rights advice and advocacy, complaint mechanisms, and establishing patients' bills of rights.

  However, we heard that human rights violations still occur. Whether or not these concerns represent inequitable treatment of people based on disability or other *Code* grounds, they may still reflect people's broader rights under the *Charter* and international law to autonomy, liberty and physical or mental integrity.

  The vulnerability of people with disabilities in mental health and other institutions and the potential for human rights abuses has been recognized internationally.[146] In 2008, the UN Special Rapporteur on Torture, Manfred Nowak, in his interim report on torture and other cruel, inhuman or degrading treatment or punishment, raised concerns about persons with disabilities worldwide being subjected to indignities in segregated settings such as prisons, social care centres, orphanages and mental health institutions.[147]

The Special Rapporteur raised concerns about the prolonged use of restraints and solitary confinement or seclusion of people with disabilities across the world, which may constitute torture or ill-treatment.[148] He also said that intrusive types of medical interventions such as electro-convulsive therapy must be based on free and informed consent, and that the forced administration of psychiatric drugs, particularly neuroleptic drugs (which are often used to treat psychosis), needs to be closely scrutinized. Depending on the circumstances of the case, and without free and informed consent, the suffering inflicted and the effects upon the person's health may constitute a form of torture or ill-treatment.[149] The Special Rapporteur went on to state that involuntary treatment and involuntary confinement specifically run counter to the provisions of the *Convention on the Rights of Persons with Disabilities (CRPD)* and that these provisions complement other conventions that prohibit torture.

- **Rights to liberty and security of the person and involuntary admission criteria:**

The *CRPD* sets out rights and obligations that relate to the issues the OHRC heard about in the consultation. The *CRPD* can provide guidance on how mental health laws, policies and programs should be designed to provide for equal treatment for people with disabilities. Article 14 (liberty and security of the person) guarantees the right of people with disabilities to not be deprived of their liberty unlawfully or arbitrarily; that any detention be in accordance with the law; and that the existence of a disability shall in no case justify a deprivation of liberty.[150] The 2009 annual report of the United Nations High Commissioner for Human Rights provides this interpretation of Article 14:

> Legislation authorizing the institutionalization of persons with disabilities on the grounds of their disability without their free and informed consent must be abolished. This must include the repeal of provisions authorizing institutionalization of persons with disabilities for their care and treatment without their free and informed consent, as well as provisions authorizing the preventive detention of persons with disabilities on grounds such as the likelihood of them posing a danger to themselves or others, in all cases in which such grounds of care, treatment and public security are linked in legislation to an apparent or diagnosed mental illness.
>
> This should not be interpreted to say that persons with disabilities cannot be lawfully subject to detention for care and treatment or to preventive detention, but that the legal grounds upon which restriction of liberty is determined must be de-linked from the disability and neutrally defined so as to apply to all persons on an equal basis.[151]

Based on the feedback we heard, the provisions of Article 14 and other articles in the *CRPD*, Ontario's mental health legislation requires a careful review. The Law Commission of Ontario is developing tools and standards to ensure closer alignment with Canada's obligations under both domestic and human rights law.[152]

- **Rights to legal capacity and supported decision-making models:**

  The rights guaranteed under Article 12 of the *CRPD* also need close examination and review as they relate to decision-making support for people with psychosocial disabilities, and determining people's capacity to make certain types of decisions. Article 12 recognizes that people with disabilities are individuals before the law and have legal capacity "on an equal basis with others in all aspects of life." According to the UN High Commissioner of Human Rights, this provision does not provide any exception.[153] Under Article 12, States Parties are to take steps to provide access to the supports that people with disabilities may require to exercise their legal capacity. The UN High Commissioner of Human Rights argues that deprivation of legal capacity based on a perceived or actual mental illness or psychosocial disability may constitute a violation of the obligations set out in article 12.[154]

  Canada has put forth a declaration and reservation about Article 12, indicating that it reserves the right to continue using substitute decision-making arrangements subject to appropriate and effective safeguards.[155] Generally under Canada and Ontario's system of guardianship, if someone is deemed to lack capacity to make decisions in a particular area, such as making decisions about their finances or personal care, these decisions are made by a substitute decision-maker, acting on a person's behalf.[156]

  Nevertheless, Article 12 requires that appropriate measures be taken to provide the person with the support they need to make decisions,[157] such as making sure a person has access to a network of people who can help. Some disability groups and scholars have argued that to achieve true substantive equality, providing supports as much as possible to help people make decisions should be recognized as part of an organization's legal duty to accommodate.[158]

Recommendation:

35. In light of the supports required under the *Convention on the Rights of Persons with Disabilities,* and the provisions of Articles 12 and 14, the Government of Ontario should review and evaluate all laws, policies and standards relating to mental health in consultation with disability groups and other stakeholders to ensure equity for people with psychiatric disabilities or addictions. This review should include Ontario's system of guardianship and involuntary admission criteria.

- **Dignity and autonomy issues:**
  Issues of freedom of choice and respect for dignity featured highly in people's experiences with the mental health system and forensic mental health settings. Some consultees said that they felt dehumanized and "warehoused" and that their concerns were not dealt with at all by their stays in hospital. We heard that there is sometimes an adversarial sentiment between staff and patients in hospital settings. Some people reported being strip-searched in front of both male and female staff. In extreme cases, people reported being harassed, assaulted or sexually assaulted by staff.

> Doctors only look for what's "wrong" with us ... they're trained to only look for pathology, and so see most problems as a pathological one that need medication and the person needs to be totally "compliant" with the inadequate medication that's being prescribed. I think it's discriminatory to only look for pathology, as it treats all people coming within a psychiatrist's care as someone who needs to be medicated, controlled, and "less capable" than others, leading to a treatment model that's flawed from the very start of the analysis.
>
> – Survey respondent

People described being treated as if they were less intelligent and less capable of making decisions. They told us they were talked to in a patronizing way, and left out of treatment decisions involving their medical care, even where they were capable of being involved. We also heard about the concerns people had about the therapeutic treatment choices offered within the mental health system. Although some individuals identified the positive benefits they experienced when taking medication, others raised issues with certain treatment methods including anti-psychotic medication and electroshock therapy, particularly where these may have negative side effects. People also described feeling that they have little choice to access alternative, non-medication-based care.

A significant theme was raised relating to the system of "privileges." As reinforcement for certain behaviours, people receive increasing levels of freedom and responsibility within the institution. Although we heard that this approach is commonly used in mental health hospitals and forensic mental health settings, individuals and organizations raised concerns that decisions about privileges may be arbitrary, inconsistent across staff, used for punishment purposes for not following staff's rules or the treatment provided, and detract from patients' dignity by removing their rights to make their own choices.

Advocates were concerned that people receive punishment for minor offences, and the rationale of safety and security are used even if these are not legitimate. We heard that in some settings, going out for fresh air, wearing one's own clothes or being able to communicate with others by using cell phones are privileges that must be earned or can be taken away. Patients' access to these or other privileges may be affected by the levels of staffing available.

A great deal of value appears to be placed on patients in the mental health system who are "compliant." Because of power differences between patients and staff, people may not be encouraged to ask questions about their care, protest poor treatment or seek advice, where it is available. This also deters people from making complaints based on *Code* grounds or asserting their rights in other ways. Such an atmosphere of expected compliance may be built into the culture of an organization. In the Kirby report, the Senate committee said that in general:

> Pejorative labels such as non-compliant, manipulative, difficult to direct, hard to serve, attention-seeking or interfering (for family members) have discredited assertive behaviours and have further silenced people.[159]

People in mental health institutions have identified that they are afraid to complain about mistreatment because they fear losing their privileges, or not being believed. For example, one person said that she and other women experienced sexual harassment during hospitalization and that their reports were not believed because this was perceived to be "part of their illness."

If this type of atmosphere exists, organizational shifts may be needed to make sure people are always treated with respect. This feedback highlights the importance of having people in hospitals with expertise in human rights who can ensure that patients receive the appropriate support, advice about their legal rights, and can get guidance on making human rights-related complaints.

- **Treatment and informed consent:**

  The Ontario Court of Appeal, in *Fleming v. Reid*, affirmed a competent person's right to determine what should be done with his or her own body, and the right to be free from non-consensual medical treatment. As well, the case found that if a person becomes incompetent, his or her prior wishes about treatment that were expressed while he or she was competent cannot be overridden. The court made the comparison that people in a psychiatric facility have just as much right to refuse to take a doctor's advice or medication as patients who have physical illnesses. Hospitalizing someone against their will does not automatically make them unable or incompetent to make treatment decisions. The court recognized that, "Mentally ill persons are not to be stigmatized because of the nature of their illness or disability; nor should they be treated as persons of lesser status or dignity. Their right to personal autonomy and self-determination is no less significant, and is entitled to no less protection, than that of competent persons suffering from physical ailments."[160]

  A number of consultees and advocates said that they or people they knew received treatment against their wishes while they were hospitalized for a psychiatric disability. Unless one has been found to lack the mental capacity to make treatment decisions, everyone has the right to refuse to consent to treatment.[76] The Empowerment Council noted that many people in institutional settings are unaware of their rights to consent to or refuse treatment, despite these being outlined in the *Health Care Consent Act*.

Some people reported not understanding or not being told of the side effects of the medication they were taking. Some said they were not formally told about their diagnosis by a medical professional, or they were not immediately told that they were under a Form 1 (involuntarily detained in hospital for up to 72 hours for a psychiatric assessment). We also heard concerns about people who arrived voluntarily at hospital but were kept on locked wards. People also said they were "coerced" into taking medication because they were told that they would not be able to leave hospital until they took it. Where providing treatment is linked to the denial of services or differential treatment in services based on disability, this raises questions about whether people are actually able to refuse treatment and raises *Code* concerns.

ACE told us that in long-term care homes, older adults, or their substitute decision-makers (if older adults are deemed incapable) are often not informed of their rights to refuse to consent to treatment. ACE says that it commonly receives complaints from substitute decision-makers who are concerned about a mentally incapable person in a long-term care home being given medication they know nothing about. To protect the security of persons by educating them about their legal options after a finding of incapacity, ACE recommended reinforcing the *Health Care Consent Act* by setting out in regulation a duty for health practitioners to provide specified rights advice, including providing notice to the person about a finding of incapacity, and providing information and assistance with respect to making appeals to the Consent and Capacity Board.

- **Community treatment orders (CTOs) and Assertive Community Treatment Teams (ACTTs):**

  Additional concerns were raised about CTOs and ACTT planning. ACTTs oversee treatment of people in the community, and ACTT planning may be used to divert people out of the criminal justice system. We heard that these measures may treat people with psychiatric disabilities in a way that is restrictive based on disability, without making sure that these restrictions are legitimately connected to the purpose of the program or people's individual circumstances. Conditions of community treatment orders may include curfews, prohibition on contact with people under a certain age, restrictions on taking public transit, or conditions that are linked to a person's tenancy. The PPAO said that restrictions in ACTT plans may have nothing to do with the initial offence. The PPAO said that these restrictions may be put in place as a condition of insurance arrangements, instead of an assessment of real risk.

Some people saw CTOs generally as coercive mechanisms to get people to seek or maintain treatment. In a 2005 review of the effectiveness of CTOs, the conclusions were divided. Some people described the positive aspects of being on a CTO, including increased stability that allowed people to stay outside hospital and the ability to reintegrate into the community. However, others said that any benefits were outweighed by the loss of personal autonomy and control.[162]

- Use of restraints:

  One person described her hospital experience following an intentional overdose:

> … After the [psychiatric] assessment, I started crying quietly and the psychiatrist ordered 4 mg of Ativan [anti-anxiety medication]. I dislike taking medication unless I know exactly what it is, but she wouldn't tell me what the side effects were or how I could expect to feel after taking the medicine. She said that I had to take it because I was too high-strung and because she needed to make sure she kept the other patients safe. That didn't make sense to me because I was laying quietly (except for the occasional sniffle) in the bed and had not been violent (verbally or physically) at all during my entire stay. … I told the nurse that I did not want to take the 4 mg of Ativan and she said that my alternative was to be physically restrained with the leather restraints attached to the bed. Needless to say, I chose the chemical restraint.
>
> – Survey respondent

The College of Nurses of Ontario defines restraints as physical, environmental or chemical measures used to control the physical or behavioural activity of a person or a portion of his/her body. Physical restraints limit a person's movement. Environmental restraints control their mobility (such as a secure unit, seclusion or "time-out" room). Chemical restraints are any form of psychoactive medication used not to treat illness, but to intentionally inhibit a particular behaviour or movement.[163]

We heard that restraint policies and practices involving people with psychiatric disabilities are not uniform across the province.[164] Patient advocates and hospital sector representatives said that there is little provincial oversight of restraint use in Ontario. Service providers such as Ontario Shores told us that promoting consistent and appropriate guidelines on seclusion/restraint use should be a goal within this sector.

Currently, restraint use is allowed in some circumstances, such as where it is necessary to prevent serious bodily harm to the person or other people. Many people in the consultation expressed serious concerns about their or other people's experiences of being restrained in a health care setting due to a mental health issue, and reported that they believed these restraints were used inappropriately. Some people told us about people being restrained for hours or days at a time. Some indicated that they weren't checked on by staff. In one case, a person described how her son was not let out to use the washroom after being physically restrained for eight hours.

We also heard that restraints or seclusion may be used to address patients who are seen as non-compliant with staff's directions or treatment. Some felt that restraints were used as a response to low levels of staffing (for example, with older adults with Alzheimer's in long-term care).[165] We heard that the use of physical restraints has particular disadvantaging effects on people with hearing disabilities because they are prevented from communicating using sign language.

Concerns about restraints have been raised in previous reports and inquest findings. The Canadian Institute of Health Information released its report on the use of restraints on people admitted to a designated mental health bed between 2006 – 2007 and 2009 –2010. It found that almost one in four people experienced some form of restraint.[166] In 2005, Jeffrey James died in hospital after being physically and chemically restrained and secluded for several days. As a result of the inquest into his death, the Coroner of Ontario recommended that all psychiatric hospitals aspire to provide restraint-free care and ensure greater involvement of patients and advocates to manage any risk factors before restraints could be used.

Also as a result of this inquest, the Registered Nurses Association of Ontario has developed clinical best practice guidelines on the use of restraints.[167] It notes that, "there is insufficient evidence to support the use of restraints including seclusion for short-term management of disturbed/aggressive behaviour in adult psychiatric settings." The guide supports the use of restraints only after all other de-escalation methods have been tried and have been proven ineffective.[168]

Restraint policies and practices could constitute *Code* violations where restraint use is based not on real health and safety risks, but on stereotyping based on one or more *Code* grounds, or if restraints are disproportionately applied against people based on *Code* grounds where they are not warranted. For example, if an African Canadian man with a psychiatric disability is restrained based on stereotypical perceptions relating to his race and disability, instead of imminent health and safety risks, this could represent a violation of his rights under the *Code*. Using restraints as a last resort after other de-escalation methods have been used, using appropriate assessments of risk, and implementing safeguards and monitoring may avoid human rights abuses.

Recommendations:

36. The Government of Ontario should create provincial rules and oversight mechanisms for the consistent use of restraints on people with mental health or addiction disabilities, with the goal of using restraints only as a last resort.

37. The Office of the Chief Coroner of Ontario should conduct a mandatory inquest into the death of any psychiatric patient who dies in psychiatric facilities or hospitals while exposed to chemical or environmental restraint (seclusion).

Protecting human rights in the psychiatric system:

Representatives of mental health institutions and hospitals, including the OHA, said that there has been a "fundamental shift" in attitudes towards people with mental health disabilities in the psychiatric system. For example, organizations said they now take into account the philosophy of recovery, they take part in developing Patients' Bills of Rights, and they fund patient and family councils that can advocate on behalf of people whose rights have been violated. Service providers pointed to legislation such as the *Excellent Care for All Act*, which promotes "client-centred" care and requires obtaining feedback from service recipients in the form of client satisfaction surveys to evaluate and improve care. Some hospitals reported that they developed a series of policies and training sessions that promote respect for rights (Ontario Shores). Finally, the CPSO has produced several policies and procedures, including a complaint procedure, that take into account professional and human rights responsibilities towards patients.

Even with these positive advances, we heard that it is extremely difficult for people to meaningfully enforce or even be aware of their rights within the psychiatric system. For systemic change to occur within the system, consultees said that more education is needed to challenge negative attitudes, particularly in medical schools. Suggestions on how to increase compliance with policies and procedures included:

- Monitoring client satisfaction and measuring potential inequities in care for *Code*-protected groups
- Tracking how well hospitals are implementing clients' Bills of Rights
- Supporting the use of advocates for clients
- Supporting greater peer support options in the mental health system
- Making sure that service users are represented in all aspects of decision-making, from the hospital boards to front-end services
- Making compliance with human rights policies and practices a requirement of hospital accreditation and staff evaluations.

The Empowerment Council told us that rights granted to people with psychiatric disabilities and addictions should be measured using an integrated reporting and assessment mechanism. Representatives from the hospital and medical sector were largely supportive of further data collection based on *Code* grounds as a key piece of measuring inequality in care or treatment.

Recommendations:

38. All hospitals, working with disability groups and the Psychiatric Patient Advocacy Office, should review and monitor the privilege system to ensure that people with mental health issues are responded to with dignity and equitably based on *Code* grounds and that other human rights concerns are also avoided.

39. All hospitals with psychiatric beds, in conjunction with the OHRC, the Ministry of Health and Long-Term Care, the Psychiatric Patient Advocacy Office, consumer/survivor groups and other appropriate stakeholders, should identify how to collect data based on *Code*-grounds to measure if people from *Code* groups are treated differently in the use of seclusion, restraints, when deaths occur, and other relevant health care issues regarding patients with mental health issues. The OHRC's guide, *Count me in: Collecting human rights-based data*, can help in this regard. Any data collection measures must ensure people's dignity and protect people's privacy.

40. As required by the *AODA*, all hospitals should develop human rights policies, accommodation policies and complaint procedures for serving and employing people with psychosocial disabilities, as well as other *Code*-protected groups.

41. Hospitals should regularly promote and give training on human rights policies and procedures to staff and patients so everyone knows their rights and responsibilities.

42. Hospitals should work with patients, patient groups and the Psychiatric Patient Advocacy Office to identify and remove barriers to making internal complaints in a hospital setting.

43. The Government of Ontario and all hospitals with mental health beds should introduce an independent ombuds system that can take discrimination and broader human rights related complaints from people in the psychiatric system, investigate these, and make findings.

44. All hospitals should ensure that no capable person is forced to receive psychiatric treatment, as per the *Health Care Consent Act* and the *CRPD*.

OHRC commitments:

C22. The OHRC will invite a provincial psychiatric institution, as well as other partners with human rights expertise in mental health, including consumer/survivor organizations, to engage in a large-scale organizational change process to address human rights concerns in service delivery to people with mental health disabilities, addictions, as well as other groups protected by the *Code*. Such a process may, among other things, involve a review of internal policies and practices, to identify and remove any discriminatory barriers.

C23. The OHRC will work with hospitals, the MOHLTC, consumer/survivor groups and other appropriate stakeholders to identify how to collect human rights-based data to measure disparities between *Code* groups in the use of seclusion, restraints and other relevant health care issues. Any data collection measures must ensure people's dignity and protect people's privacy.

e) The criminal justice system

Police

Many individuals and organizations commented on the role of police in responding to people with mental health issues and addictions. The Provincial Human Services and Justice Coordinating Committee (PHSJCC) said that more community resources must be put in place in urban and rural areas so that police are not the default responders to people with mental health crises. In 2011, the Ontario Association of Chiefs of Police passed a resolution that supports de-emphasizing the role of police in mental health and addiction cases, because people are best served by health care professionals in the community.[169] One police representative stated that when police respond to people who are mentally ill it perpetuates stereotypes that people are a risk to others.

Other participants in the consultation reported that in their interactions with police, they were either underserviced or responded to in inappropriate ways based on disability. For example, many consumer/survivors remarked that when police are aware that the individual making the complaint has a mental health issue, they tend to dismiss the person's allegations or not take appropriate action.

> If you have a known mental illness, the [police] disregard anything you have to say. I no longer call them for assistance (I live in a really bad neighbourhood) and just keep bats at my door to protect myself and my son from break-ins.
>
> – Survey respondent

In addition, we heard that police are not properly trained to de-escalate situations where people experience a mental health crisis. The Metro Toronto Chinese and Southeast Asian Legal Clinic (MTCSALC) stated that since the 1997 shooting of Edmond Yu, a person with a mental health issue, "there has been little change in police practices in this respect. Reports of police harassment, the use of excessive force, and the overcharging of people with mental health issues remain unabated." CMHA Ontario said that persons with mental illness are more likely than others to be approached or arrested for minor or "nuisance" offences such as "trespassing" or "disorderly conduct." It added that the "number of people with mental disorders who come into conflict with the justice system is increasing at the rate of about 10 percent a year, though the number of those considered violent is actually declining."[170]

Many people raised concerns about treatment by police, especially the use of force, when they experienced crisis episodes and needed to be taken to hospital under the *Mental Health Act*.[171] In May 2012, after several people with mental health disabilities were lethally shot by police, the Minister of Community Safety and Corrections announced an internal government review of how police respond to people who may be experiencing a psychiatric crisis.[172]

> When ill and needing to be hospitalized, I was treated in what I would call a brutal manner by the police who responded to the 911 call. I was ill, not engaged in any criminal activity. As an ill person, I should have been transported by medical personnel, in an ambulance, not in a police car with handcuffs.
>
> – Survey respondent

> I called the police to come pick up my son and take him to the hospital (I had a court order) ...They arrived with Tasers and I was told they would use them if necessary ... What do you think will happen when four or five police officers arrive to pick up an individual with a mental illness (who is very frightened) and the officers have their hands on Taser guns?
>
> – Survey respondent

CMHA Ontario was concerned about the tendency for law enforcement to use Tasers (conducted energy weapons) on people experiencing a mental health crisis or showing signs of emotional distress. They recommend that in addition to using crisis intervention teams to appropriately respond to people in crisis, police services in Ontario must limit their use of Tasers to situations where the alternative would be use of deadly force. CMHA Ontario recommends that police services monitor and publicly report the incidence and outcomes of Taser use. In addition, it calls for independent research to be conducted into the safety of Taser use, including the effects on persons experiencing a mental health crisis.[173]

Many consultees voiced their support for crisis response teams. Several police services across Ontario work collaboratively with community agencies to establish these teams, in which crisis response workers attend with police as a way to de-escalate situations when people experience psychiatric emergencies. The York Support Services

Network and York Regional Police told us that their mobile crisis response team has had a considerable impact on the attitudes among police about persons with mental illness, and on attitudes within the local community about police. Police officers in general can play an important role in accommodating people's disabilities by diverting people with psychosocial disabilities away from the criminal justice system when offenses are minor and appear to be linked to a psychiatric disability.

Other consultees noted some drawbacks to these teams. We heard that tensions may escalate between an individual experiencing a crisis if uniformed police officers respond first, before the crisis response worker. As well, crisis response teams are not available in all regions at all times of the day. We also heard that the type of training provided to crisis response teams should be made more broadly available to all police, given that dealing with people in psychiatric distress is a core part of their work, and that by having specialized police services, it reinforces the idea that the consumer/survivor community is separate.

We heard that people with mental health issues or addictions may be singled out by police for harassment or forceful treatment for exhibiting behaviour related to disability, or for having a known mental health issue. One person spoke of being "aggressively" accused by police of "snorting" drugs for making sniffing noises, when this was a tic related to having Tourette syndrome, and stated,

> It made me very aware that this officer made an assumption by first sight. To me it's the same as seeing someone who is diabetic, maybe their insulin is low, they start acting like they're drunk. Police need to have more awareness of symptoms.
>
> – Focus group participant

Some police services, such as the Toronto Police Service, have set up mental health consultative groups to provide community input on policing issues related to people with mental health issues. If given the appropriate mandate, these bodies can play a powerful role by examining themes and trends, weighing in on complex issues and helping to guide service delivery that upholds human rights.

Recommendations:

45. The Ontario Police College and police services should provide training to new and seasoned police officers on human rights and the duty to accommodate people with mental health issues or addictions. All officers, including new recruits and seasoned officers, should also receive training in crisis response de-escalation techniques used by specialized crisis response teams.

46. Police services should set up community committees, which include consumer/survivors and people with addictions, to advise police about issues relating to mental health and police service delivery.

Recommendations:

47. Police services should develop police policies and protocols that address human rights and policing issues as they relate to people with mental health disabilities and addictions.

48. Police services should collect data to identify any inequities in the treatment of people with perceived or known mental health disabilities or addictions compared to people without mental health disabilities or addictions.

OHRC commitment:

C24. In its work with police services in Ontario, the OHRC will raise issues about discrimination against people with mental health or addiction disabilities in service delivery, and will work with police to build capacity to address these concerns.

Courts and legal representation

> Yes, people warn you, "don't go to court you will not be able to handle the stress." And people exploit you as they know that you are mentally not up to the mark.
>
> – Survey respondent

Among the concerns raised about accessing justice through the court process was that it was very difficult for some people with psychosocial disabilities to gain access to legal support, because they could not afford legal counsel and had difficulties accessing the application process for Legal Aid. Without legal representation, people with mental health issues may be doubly disadvantaged if they appear in court while experiencing psychiatric symptoms. This issue was also a concern for people going through tribunal processes.

> Judges would ask, "Do you understand what we were asking you?" I had mental [health] issues and I was facing criminal charges. I didn't have a lawyer. His questions were twenty minutes long. I couldn't understand what he was saying.
>
> – Participant in Toronto roundtable session

Other issues were raised about equal treatment in the legal process. Some people were concerned that a witness's mental health issue can be exploited by counsel on the opposite side, leaving people to feel victimized or leading to the person losing their case. We also heard that lack of education and awareness of mental health issues and addictions among decision-makers and court personnel was also a concern.

> Most of my clients are also involved with the justice system, and it's really scary when you are in front of a judge explaining your clients' mental issues and the judge is not even familiar with the different forms of mental health issues such as ADD [attention deficit disorder], OCD [obsessive/compulsive disorder], ODD (oppositional defiant disorder), etc.
>
> – Survey respondent

A representative from Ontario's court system said that efforts are being made to make courts more accessible. For example, courthouse accessibility co-ordinators can take requests for accommodation. Plain language is being increasingly used for key documents for the public, and where a service counter environment is noisy, people have been given quieter spaces to have conversations. With judicial approval, hearings can be rescheduled to accommodate people's symptoms if needed. Other types of accommodations that may be required in a court or in any decision-making process include private hearings, adjournments where needed, pre-hearing conferences, and human support to connect to legal services.[174]

- **Diversion courts:**

  Although the programs differ across regions, mental health and "drug court" diversion court programs were developed to provide mental health services and supports to people with mental health needs and addictions who are in contact with the justice system. A person may be eligible for diversion court if their alleged offense is considered to be low-risk and their health needs can be met through community-based services. Diversion courts are designed to "divert" people from the corrections system which has not been able to adequately address mental health-related needs.

  Clients can voluntarily take part in the program. However, one legal academic said that mental health courts were created because of inadequacies of supports in the community, and that they emerged out of a discriminatory environment in the criminal justice system. The Empowerment Council stated that the efficacy of diversion courts in upholding individuals' rights needs to be established empirically.

  Many people told us that diversion courts have made a positive impact in successfully diverting people from the criminal justice system into the mental health system. However, the MTCSALC said that not everyone who would benefit from diversion court is able to access it, because not everyone with mental health issues is being identified by the police or crown attorneys. It stated that, "those with undiagnosed issues will end up in the regular criminal court facing a potentially harsher sentence for their 'crime'."

The Provincial Human Services and Justice Coordinating Committee told us that court support programs do not have the ability to handle more complex cases, including people with concurrent substance use disorders, or a co-occurring dual diagnosis (intellectual disability). It suggests that an estimated 80% of people referred to mental health services from the justice system have an addiction problem or concurrent disorder.

Other consultees had concerns about the "separate" nature of the diversion court system, and told us that a more integrated and equitable approach would be to ensure that any need for accommodation based on disability is dealt with through a regular trial. We heard about concerns about the degree to which the courts assess people on an individualized basis and provide appropriate treatment plans. One representative from a consumer/survivor initiative said that people are left out of decisions about what they need, and that treatment plans can place restrictions on the types of services the person has to use.

Recommendations:

49. The Canadian Judicial Council and the National Judicial Institute should provide training to all judges on human rights and accommodating people with psychosocial disabilities during the hearing process.

50. The Ministry of the Attorney General, the Law Society of Upper Canada and the Ontario Bar Association should arrange training for lawyers and court staff on human rights issues and accommodating people with mental health issues or addictions during the hearing process.

51. The Ministry of the Attorney General and Legal Aid Ontario should examine their policies, processes and practices and remove barriers to access and improve accommodation for users with mental health issues or addictions.

Corrections system

> The jails are the worst place to be mentally ill. They are not equipped to deal with the situation. A person could have a manic episode – yelling and stuff. The only thing the guard can do is tell you to shut up and put you in seclusion. That makes it so much worse. Once I was in trouble in the jail, they couldn't figure out what to do with me, I was in seclusion and I just got worse. Eventually I got sent to a place that blends nursing and jails. That place saved my life.
>
> – Focus group participant

In its 2008-2009 annual report, the federal Office of the Correctional Investigator, which acts as an Ombudsman to federal offenders, noted the comments of the federal Minister of Public Safety, who stated that over the past 30 years, Canada has progressively moved toward a community and outpatient system of "de-institutionalizing" the mentally ill from provincial facilities, only to discover that it is "re-institutionalizing" them as prisoners, thereby suggesting that Canada is "criminalizing the mentally ill."[175] The report goes on to state that 39% of inmates in Ontario have been diagnosed with a mental illness, have a current medication order in effect, or are receiving ongoing psychiatric evaluation or psychological intervention. For persons with addictions in the federal justice system, 50% of Canadian offenders report substance abuse as a cause of their offence.[176]

Consultees were concerned that many people with psychosocial disabilities were in prison for relatively minor offences. Many people were particularly alarmed that certain *Code*-protected populations are highly represented in the corrections system, including racialized and African Canadian men, Aboriginal Peoples, people with learning disabilities and people with fetal alcohol spectrum disorder, which can reflect systemic discrimination against these groups.[177]

A major issue was the lack of availability of adequate mental health services for people in the corrections system (OHA) and limited access to physicians or treatment. We also heard concerns that people with some psychiatric disabilities may not be properly accommodated in the prison system by experiencing unwarranted interruptions in their treatment – for example, by not being given medication they need. Consultees were concerned that these types of practices can be dangerous for people's conditions. The OHRC is aware of concerns that people in correctional facilities may have limited access to commonly prescribed medications, and may have their existing treatment plan altered without an in-person assessment by a physician.

The Provincial Human Services and Justice Coordinating Committee told us there are more clients on remand in Ontario than people who have been convicted, and many of them have a mental health issue and/or addiction. However, these individuals are not receiving psychiatric assessments mandated by the court, or adequate mental health or addiction services while awaiting their trial date, particularly in rural areas.

In June 2012, the UN Committee on Torture raised concerns about the state of prisoners with mental illness in Canada. To conform with UN standards, it said that Canada should, among other things, increase the capacity of medium and acute mental health treatment centres for prisoners, and abolish solitary confinement for people with serious mental illnesses.[178]

OHRC commitment:

C25. The OHRC, in its human rights work with the Ministry of Community Safety and Correctional Services (MCSCS), will include as a focus concerns about the lack of accommodation of people with mental health issues and addictions, particularly as these intersect with other *Code* grounds including race and related grounds, other forms of disability, and sex.

Criminal records

People with mental health issues or addictions may receive a criminal record after going through the court process for incidents relating to their disability, such as disorderly conduct or more serious offences. Many concerns were raised about the profound impact that a criminal record has on a person's ability to get housing, employment, volunteer work and services – such as post-secondary education, physicians, psychiatrists or community mental health programs (OHA, Provincial Health and Services Justice Coordinating Committee). The *Code* prohibits discrimination in employment against someone who has a criminal record but has received a pardon. This type of protection is narrow and does not exist in other social areas covered by the *Code*.

The Metro Toronto Chinese and Southeast Asian Legal Clinic said that having a criminal record will have further effects on a person who is racialized. Permanent residents may face deportation even if the criminal record stems from behaviour that is linked to a disability. Pardons can be difficult to get if a person has low income, which may also have an adverse effect on people with mental health disabilities or addictions.

14. Rights awareness and enforcement

14.1. Complaint mechanisms

Many people with mental health issues or addictions told us they were largely unaware of the right to be free from discrimination based on a psychiatric disability or addiction in housing, employment and when receiving services. At the same time, it appears that organizations also lack awareness of their responsibilities under the *Code*. Even where people were aware of their rights, many reported experiencing great difficulty enforcing these rights, whether pursuing complaints through the organization they were concerned about, the human rights system, or other decision-making bodies, such as administrative tribunals or the Courts.[179] We heard that ways to enforce rights were critical to correcting and preventing human rights violations that people experience. However, many people were not aware that there was a human rights system they could use to challenge discrimination.

We heard that people were often prevented from accessing complaint systems because of symptoms related to their disabilities, and they felt overwhelmed with managing their day-to-day lives, particularly due to factors related to poverty. The OASW told us that, "individuals with mental illness who have a largely transient lifestyle are likely more prone to experiences of discrimination and may have a reduced ability to seek redress through formal systems, due to lack of an address and phone number for follow-ups and continually changing life circumstances."

We also heard how the requirements to make a complaint (such as application forms) are often complex or intimidating and are designed without considering the needs of people with psychosocial disabilities. For example, we heard that requiring extensive evidence to prepare for a hearing at an administrative tribunal may a barrier for people who have memory difficulties due to post-traumatic stress disorder.

> **Knowing your human rights does not mean you're going to pursue them. The issue is not of awareness; the accessibility of voicing concerns and [raising] issues of human rights is not available. The issue is of accessibility, and reaching out of the human rights system to the people suffering discrimination.**
>
> – Focus group participant

ARCH stated that administrative tribunals must have appropriate and fair processes for people who have been found to be incapable of making specific decisions. It said that when a person is believed to be incapable, tribunals may search for a "quick fix": a substitute decision-maker, or someone who can make decisions on the complainant's behalf. This approach may be invasive. It can extend beyond the tribunal's process, and it may not respond appropriately to the person's individual decision-making abilities. ARCH advises that instead, tribunals should consider using a continuum of flexible approaches that respond by first accommodating someone's decision-making abilities. For unrepresented complainants, for example, it suggests appointing a friend of the court, or *amicus curiae*, to maximize respect for the person's choices and provide the tribunal with the information it needs to evaluate the claim.[180]

Because of these concerns, a large number of consultees asked the OHRC to provide human rights education to people with psychosocial disabilities, housing providers, employers, service providers, the general public, and decision-makers such as administrative tribunals. The OASW recommended increased access to Ombudsman services to enhance individuals' abilities to complain about services, particularly for people with transient lives.

> Several administrative tribunals across Ontario have conducted training on how to accommodate the needs of people with mental health disabilities and addictions during the tribunal process. Training has also been done by the OHRC. For more information, see the Society of Ontario Adjudicators and Regulators (SOAR) website at www.soar.on.ca/events/index.php.

Recommendations:

52. The Society of Ontario Adjudicators and Regulators (SOAR) and SOAR Administrative and Management Network (SAMN) should continue to ensure that new and existing adjudicators and staff receive training on the *Code*, including how to accommodate people with mental health issues or addictions during the tribunal process.

53. Administrative tribunals and other complaint-handling and decision-making bodies should examine their policies and procedures to identify and eliminate any barriers that prevent people with mental health issues or addictions from accessing these services. As part of this process, decision-makers should use approaches that maximize participation and accommodate the needs of people who may experience difficulties with decision-making capacity.

OHRC commitment:

C26. The OHRC will continue to work with administrative tribunals in Ontario to provide training on human rights, including the duty to accommodate, where these relate to serving people with psychiatric disabilities and addictions, as well as other *Code*-protected groups.

14.2. Advocacy

> When I went to my doctor he didn't have a clue. His first reaction was, "Well, I'm a doctor and I know what I'm doing." Not everyone has the ability to say to the doctor, "Look it up." You need an advocate; people with mental health problems need an advocate.
>
> – Participant in North Bay roundtable session

A significant number of consultation participants said they had great difficulty accessing rental housing, psychiatric hospitals, ODSP, insurance benefits, administrative tribunals and other services equitably without the help of someone advocating on their behalf, particularly when they were not well. Many people also identified the need for human support, advocates and advocacy to help them navigate systems, increase their and others' awareness of their rights, avoid discrimination and make complaints.

Advocacy can be seen as an important form of human support and a method of accommodating people's needs. At the same time, the widespread call for advocates points to the need for organizations and services to design and deliver their services inclusively without discrimination and to remove barriers that prevent people from acting on their own behalf (see section 13.2. for more information on inclusive design of services).

> I find it frustrating on behalf of the clients that they can't get services on their own. The client is willing and they try and then get shut down; their calls will not be returned. I pick up the phone and I get someone and it is easily done. My clients are relieved but frustrated. Why does it have to take another person to get through? My client loses their independence; the client should not have to go through hoops and barriers.
>
> – Participant in North Bay roundtable session

Advocacy roles may be played by many different individuals in different settings. For example, peer support workers were seen as one positive form of advocacy. In psychiatric hospitals, advocacy on behalf of individuals and people with psychiatric disabilities as a group is carried out by patient and family councils and the Psychiatric Patient Advocacy Office (PPAO), which also has a legislated mandate to provide rights advice to patients.

Consultees pointed out how socio-economic status can affect people's access to services. They told us that people with higher incomes are more able to access services than people with low incomes, because people with higher incomes are more likely to have someone to assist them.

Consumer/survivor groups and other organizations have emphasized the importance of independent advocacy for consumer/survivors who may find it very difficult to complain, particularly with barriers in place that may worsen real or perceived differences in power between service providers and service users. The Ontario Association of Social Workers and others told us that people face considerable risk of losing services, housing or employment as a result of making a complaint of discrimination, particularly if they depend on these systems to access basic health needs. This may make it particularly difficult to complain when different resources are directly linked to each other; for example, where a landlord also provides support services for someone with a mental health issue in a supportive housing environment.[181]

Some people took different approaches to the concepts of advocacy and self-help. For example, we heard that people's capacity to self-advocate should be supported. As stated previously, working with people's advocates does not remove an organization's obligations to design inclusively, remove barriers, or measure and eliminate systemic discrimination.

Recommendation:

54. The Government of Ontario and organizations addressing the needs of people with mental health issues or addictions should actively support and work with mental health advocacy services that assist people to realize their rights within housing, services and mental health hospitals. The independence of advocacy services should be considered as one factor in ensuring that people are able to assert their rights without concerns about conflict of interest. Organizations training advocates should provide training on human rights, including people's rights under the *Code*.

Appendices

Appendix 1: Index of recommendations and OHRC commitments

The following list compiles the recommendations and OHRC commitments found at the end of each section of this report.

Recommendations

General:

1. The Government of Ontario should address its obligations under the *Convention on the Rights of Persons with Disabilities* **in full** to promote human rights and fundamental freedoms for all persons with psychosocial disabilities. This includes actively promoting an environment where people with psychosocial disabilities can and are encouraged to take a full part in the conduct of public affairs (Article 29).
2. The Government of Ontario should measure and report to the public of Ontario on the inequities that create the conditions for discrimination against people with mental health disabilities or addictions (such as unemployment and low income) and efforts to address these conditions. Such a report should be submitted to the federal government as part of its reporting requirements under Article 35 of the *CRPD*.
3. Organizations and individuals across Ontario should work to enhance efforts to challenge stereotypes about people with mental health issues or addictions by implementing and actively taking part in anti-stigma and education campaigns.
4. The Government of Ontario, whenever considering budget restraint measures that affect services, housing and employment for people with low income, should particularly take into account the goals identified in the Poverty Reduction Strategy and the needs of people with psychosocial disabilities, people living in poverty, and other groups protected by the *Code*.
5. The Government of Ontario should enhance and improve social assistance, including reviewing and improving benefits, to make sure that people can afford the necessities of life such as food, clothing, adequate shelter and other needs.

6. The Government of Ontario and organizations providing services to people with mental health and addictions should work to identify and eliminate discrimination based on disability in their services, as well as discrimination based on age, sex, race and related grounds, gender identity, sexual orientation and other *Code* grounds. This may require a process of examining policies, practices and decision-making processes and removing barriers that lead to discrimination for *Code*-protected groups (see the OHRC's *Guidelines on developing human rights policies and procedures* for more information).

7. The Accessibility Directorate should consult with people with psychosocial disabilities and disability groups to evaluate the current *AODA* standards to see how well they take into account the needs of people with psychosocial disabilities. Based on the feedback from consultees, the standards should be modified to take into account any additional accessibility requirements.

8. The Accessibility Directorate should develop and promote further education materials that show how the *AODA* specifically applies to people with mental health disabilities or addictions, so organizations understand their responsibilities towards people with psychosocial disabilities.

Housing

9. The Government of Ontario should link social assistance, including shelter allowance, to the real cost of rental housing in regions across Ontario.

10. The Government of Ontario should ensure more social housing options as well as subsidy alternatives, such as a portable housing allowance, to open up opportunities for people with low incomes in the private rental housing market and to permit greater flexibility in terms of where one may live.

11. Because people with mental health issues or addictions are disproportionately likely to be in need of housing, the Government of Ontario and municipalities should consider inclusionary zoning measures: laws and bylaws that require developers and municipalities to set aside a percentage of new housing for affordable housing, or a percentage of housing to accommodate persons living with mental health issues or addictions.

The recommendations the OHRC made in *Right at Home* should be implemented, including:

12. That the Government of Canada adopt a national housing strategy, in consultation with provincial, territorial and municipal governments, that includes measurable targets and provision of sufficient funds to accelerate progress on ending homelessness and ensuring access of all Canadians, including those of limited income, to housing of an adequate standard.

13. That the Government of Ontario enhance its existing Affordable Housing Strategy by providing sufficient funds to accelerate progress on ending homelessness and ensuring access of all Ontarians, including those of limited income, to housing of an adequate standard without discrimination.

14. That the Government of Ontario review and improve funding rates, programs, laws and regulations in the Province of Ontario to make sure that low-income tenants are able to afford average rents, food and other basic necessities. Specific attention should be given to:

- Ensuring that minimum wage rates are indexed to inflation and allow a full-time earner to live above the poverty line
- Assessing impacts of rent control/vacancy decontrol
- Address claw backs in income facilitated by the *Housing Services Act* and social assistance programs.

15. Supportive housing providers, working with people with mental health issues and/or addictions, should examine their application processes to ensure that the information collected is necessary and does not inadvertently create barriers for people with mental health disabilities or addictions or violate people's rights to privacy. Before rejecting an individual, each housing provider must consider its obligations under the *Code* to assess a person's individualized needs, and accommodate the person to the point of undue hardship.

16. As outlined in the OHRC's submission to the Ministry of Municipal Affairs and Housing, the government of Ontario should amend the Provincial Policy Statement which provides direction on land use planning matters, to:

- Confirm a commitment to human rights
- Lay out expectations for municipalities to review and remove barriers to affordable housing development that could lead to discrimination against groups protected by the *Human Rights Code*.
- Lay out mechanisms of accountability for removing discriminatory barriers to affordable housing development.
- Outline clearer expectations that municipalities will increase affordable housing in their communities.

17. Municipalities across Ontario should review their zoning and rental housing licensing bylaws to eliminate barriers to housing and services used by people with mental health issues or addictions (such as group homes or addiction treatment centres). Municipalities should remove any non-legitimate or non-*bona fide* requirements that apply to housing or services used by people with psychosocial disabilities that do not apply to housing of a similar scale or similar types of services.

18. The Government of Ontario should support social, co-operative and private housing providers to ensure that they meet their duty to accommodate. This could include ensuring there are sufficient third-party agencies available to assist with tenants' accommodation needs.

19. Social, co-operative and for-profit housing providers should develop human rights expertise so they can provide housing-related human rights advice, mediate and investigate complaints, where appropriate, and do barrier reviews of their policies and procedures.

Employment

20. The OACP and other agencies should actively promote implementation of the OACP police record check guideline across police services, vulnerable sector agencies and other employers including the Government in Ontario.

21. The Mental Health Commission of Canada and the Canadian Association of Chiefs of Police should promote the principles of the OACP police record check guideline with police and vulnerable sector agencies in other Canadian jurisdictions.

22. The Ontario Police College and the OACP should organize training and enhance their existing training on the police record check guideline. The OACP should oversee evaluation of the guideline, with community stakeholders and disability groups. After the guideline is evaluated, the Government of Ontario should consider whether legislative changes are needed to make the guideline more effective.

23. The Government of Ontario, the private sector and the non-profit sector should create new opportunities for special employment, supported employment, alternative businesses, employment equity practices and other special employment programs for people with mental health issues and addictions.

24. Organizations that fund special employment or supported employment programs, and organizations that have special employment or use supported employment programs, should review their funding and employment policies and remove any inequities that expose people with psychosocial disabilities to different terms and conditions of employment from those of employees doing comparable work that do not take part in these programs.

25. The Government of Ontario, the private sector and the non-profit sector should review their hiring, promotion, retention, discipline, accommodation and termination policies to remove discriminatory impacts on people with mental health disabilities and addictions to ensure equal opportunity.

26. The Government of Ontario and the Workplace Safety and Insurance Board should change the *WSIA* and the policy provisions governing workplace insurance benefits to reflect recent legal decisions. They should ensure that there is equality of benefits for people who experience physical disabilities and people who experience mental health disabilities as a result of workplace incidents.

27. All employers should develop human rights policies and procedures outlining their organization's obligations under the *Human Rights Code*, including the duty to accommodate people with psychosocial disabilities to the point of undue hardship. Employers should ensure their human rights policies identify that people with mental health issues and addictions are protected under the ground of disability, and eliminate systemic barriers in the workplace (such as in their organizational culture) that may exclude or disadvantage people with mental health issues and addictions.

28. All employers should train their employees and managers on their responsibilities under the *Code* regarding the human rights issues that affect people with mental health disabilities and addictions. This training should address preventing and responding to discrimination and harassment, systemic issues affecting people with psychosocial disabilities and the duty to accommodate.

Services

6. The Government of Ontario and organizations providing services to people with mental health and addictions should work to identify and eliminate discrimination based on disability in their services, as well as discrimination based on age, sex, race and related grounds, gender identity, sexual orientation and other *Code* grounds. This may require a process of examining policies, practices and decision-making processes and removing barriers that lead to discrimination for *Code*-protected groups (see the OHRC's *Guidelines on developing human rights policies and procedures* for more information).

29. The Government of Ontario should look for and correct inequities in health care, rehabilitative and support services for people with mental health disabilities or addictions compared to general health care.

30. In accordance with the *AODA* and the *Code*, services should review their policies, practices, application forms and decision-making procedures, working with consumer/survivor groups and accessibility experts to identify and eliminate barriers that may result in inequitable treatment for people with psychosocial disabilities or addictions.

31. The Commission for the Review of Social Assistance in Ontario should look at inaccessibility of the social assistance system for people with mental health issues and addictions, and make sure social assistance policies and practices do not have a negative impact on people identified by *Human Rights Code* grounds, including mental health and addictions.

32. The College of Physicians and Surgeons (CPSO), the Ministry of Health and Long-Term Care, should consult with the OHRC and disability groups, to increase compliance with the CPSO's policy on accepting new patients.

33. The College of Physicians and Surgeons of Ontario should review its complaint policies and procedures and eliminate barriers that may make it difficult for people with mental health and addiction issues to complain about poor professional practices.

34. The College of Physicians and Surgeons of Ontario, the Ontario Medical Association, the Ontario Hospital Association and the Ministry of Health and Long-Term Care should train doctors and medical students about their obligations under the *Code* to not deny service to people based on *Code* grounds.

35. In light of the supports required under the *Convention on the Rights of Persons with Disabilities*, and the provisions of Articles 12 and 14, the Government of Ontario should review and evaluate all laws, policies and standards relating to mental health in consultation with disability groups and other stakeholders to ensure equity for people with psychiatric disabilities or addictions. This review should include Ontario's system of guardianship and involuntary admission criteria.

36. The Government of Ontario should create provincial rules and oversight mechanisms for the consistent use of restraints on people with mental health or addiction disabilities, with the goal of using restraints only as a last resort.

37. The Office of the Chief Coroner of Ontario should conduct a mandatory inquest into the death of any psychiatric patient who dies in psychiatric facilities or hospitals while exposed to chemical or environmental restraint (seclusion).

38. All hospitals, working with disability groups and the Psychiatric Patient Advocacy Office, should review and monitor the privilege system to ensure that people with mental health issues are responded to with dignity and equitably based on *Code* grounds and that other human rights concerns are also avoided.

39. All hospitals with psychiatric beds, in conjunction with the OHRC, the Ministry of Health and Long-Term Care, the Psychiatric Patient Advocacy Office, consumer/survivor groups and other appropriate stakeholders, should identify how to collect data based on *Code* grounds to measure if people from *Code* groups are treated differently in the use of seclusion, restraints, when deaths occur, and other relevant health care issues regarding patients with mental health issues. The OHRC's guide, *Count me in: Collecting human rights-based data*, can help in this regard. Any data collection measures must ensure people's dignity and protect people's privacy.

40. As required by the *AODA*, all hospitals should develop human rights policies, accommodation policies and complaint procedures for serving and employing people with psychosocial disabilities, as well as other *Code*-protected groups.

41. Hospitals should regularly promote and give training on human rights policies and procedures to staff and patients so everyone knows their rights and responsibilities.

42. Hospitals should work with patients, patient groups and the Psychiatric Patient Advocacy Office to identify and remove barriers to making internal complaints in a hospital setting.

43. The Government of Ontario and all hospitals with mental health beds should introduce an independent ombuds system that can take discrimination and broader human rights related complaints from people in the psychiatric system, investigate these, and make findings.

44. All hospitals should ensure that no capable person is forced to receive psychiatric treatment, as per the *Health Care Consent Act* and the *CRPD*.

45. The Ontario Police College and police services should provide training to new and seasoned police officers on human rights and the duty to accommodate people with mental health issues or addictions. All officers, including new recruits and seasoned officers, should also receive training in crisis response de-escalation techniques used by specialized crisis response teams.

46. Police services should set up community committees, which include consumer/survivors and people with addictions, to advise police about issues relating to mental health and police service delivery.

47. Police services should develop police policies and protocols that address human rights and policing issues as they relate to people with mental health disabilities and addictions.

48. Police services should collect data to identify any inequities in the treatment of people with perceived or known mental health disabilities or addictions compared to people without mental health disabilities or addictions.

49. The Canadian Judicial Council and the National Judicial Institute should provide training to all judges on human rights and accommodating people with psychosocial disabilities during the hearing process.

50. The Ministry of the Attorney General, the Law Society of Upper Canada and the Ontario Bar Association should arrange training for lawyers and court staff on human rights issues and accommodating people with mental health issues or addictions during the hearing process.

51. The Ministry of the Attorney General and Legal Aid Ontario should examine their policies, processes and practices and remove barriers to access and improve accommodation for users with mental health issues or addictions.

52. The Society of Ontario Adjudicators and Regulators (SOAR) and SOAR Administrative and Management Network (SAMN) should continue to ensure that new and existing adjudicators and staff receive training on the *Code*, including how to accommodate people with mental health issues or addictions during the tribunal process.

53. Administrative tribunals and other complaint-handling and decision-making bodies should examine their policies and procedures to identify and eliminate any barriers that prevent people with mental health issues or addictions from accessing these services. As part of this process, decision-makers should use approaches that maximize participation and accommodate the needs of people who may experience difficulties with decision-making capacity.

54. The Government of Ontario and organizations addressing the needs of people with mental health issues or addictions should actively support and work with mental health advocacy services that assist people to realize their rights within housing, services and mental health hospitals. The independence of advocacy services should be considered as one factor in ensuring that people are able to assert their rights without concerns about conflict of interest. Organizations training advocates should provide training on human rights, including people's rights under the *Code*.

OHRC Commitments

General

C1. The OHRC will notify the organizations about the recommendations it has made, and offer to assist in implementing these, where possible.

C2. The OHRC will work with community stakeholders to enhance public education on human rights and mental health.

C3. The OHRC will conduct training on its policy on mental health and addictions throughout the province with consumer/survivors, people with addictions, government, as well as public and private-sector organizations.

C4. In its work on its strategic priorities (e.g. policing and anti-racism, Aboriginal Peoples' human rights, family status, disability and education), the OHRC will build in a focus on human rights, mental health and addictions.

C5. The OHRC will further examine the issue of the level of rights advice provided to older adults in long-term care who are deemed to be incapable of making treatment decisions. If this has the potential to violate the *Code*, the OHRC will, where appropriate, raise concerns with the responsible parties, do public interest inquiries, intervene in legal cases and/or launch Commission-initiated applications.

C6. The OHRC will develop a policy on human rights, mental health and addictions, that will build on its *Policy and guidelines on disability and the duty to accommodate*. In writing its policy, the OHRC will provide guidance, with examples, on how organizations can meet their duty to accommodate people with psychosocial disabilities at work, in housing and in services. This discussion will take into account the concerns raised in the consultation, the responsibilities of people and organizations during the accommodation process, and the limits of accommodation (undue hardship).

C7. The OHRC will raise awareness with the Ontario Medical Association, the College of Physicians and Surgeons and other relevant stakeholders of how the medical community can support individuals' requests for accommodation where medical verification of a person's limitations and needs are required to make an accommodation.

C8. The OHRC will monitor emerging issues related to mental health and addictions through requests for legal intervention from the community, examining the media, networking with community organizations and the Human Rights Legal Support Centre, and other approaches. The OHRC will consider using its mandate to address these issues by, where appropriate, doing public education, policy development, launching public interest inquiries, legal interventions and/or Commission-initiated applications at the Human Rights Tribunal of Ontario.

C9. In its policy on human rights, mental health and addictions, the OHRC will provide guidance on distinguishing the duty to accommodate from providing treatment or care to someone with a mental health issue or addiction. It will also provide guidance on when the *Code* may apply when organizations deny services or housing to people with psychosocial disabilities.

Housing

C10. The OHRC will continue to promote its guide, *In the Zone: Housing, human rights and municipal planning* and provide education to municipal councils, planners, legal clinics, developers, neighbourhood associations, tenant associations and other stakeholders on their rights and responsibilities under the *Code* to prevent discriminatory opposition to affordable housing.

C11. As per the commitments it made in *Right at Home*, the OHRC will continue to be available to consult with community organizations, municipalities/municipal associations and the Government of Ontario to help develop and implement a province-wide strategy to address and prevent discriminatory NIMBY opposition.

C12. The OHRC will continue to use its mandate to actively challenge discriminatory NIMBY opposition through, where appropriate, working with municipal councils, conducting public interest inquiries, pursuing legal challenges, and other initiatives.

C13. The OHRC will examine the issue of mandatory treatment conditions in private, social and supportive housing in its policy on mental health and addictions and will provide further guidance to landlords and housing providers.

C14. The OHRC will continue to provide education on human rights and rental housing to tenants, landlords, housing providers and others, and will include a focus on human rights, mental health and addictions.

Employment

C15. The OHRC will raise the issue of the disclosure of mental health information that prevents people from entering the United States, with the Canadian Human Rights Commission.

C16. The OHRC and the Ministry of Labour will discuss the impact of disclosure requirements under the *OHSA* on people with mental health issues, and consider how this issue could be monitored and addressed.

C17. The OHRC will approach the College of Nurses of Ontario and any other relevant stakeholders to remove barriers that prevent nurses with mental health disabilities from accessing employment. The OHRC will consider using its mandate, which could include building partnerships, conducting public interest inquiries, intervening in cases, and/or pursuing Commission-initiated applications to address this issue.

C18. The OHRC will continue to provide education on human rights and the workplace to employers, employees and unions, and will include a focus on human rights, mental health and addictions.

Services

C19. The OHRC will examine further the policies or processes of driver's licence suspension, child protection or insurance policies and consult with the appropriate government ministries and stakeholders to consider whether these contravene the *Code*. Where these practices have the potential to violate the *Code*, the OHRC will address these concerns using the functions in its mandate.

C20. The OHRC will be available to consult with the College of Physicians and Surgeons and the Ministry of Health and Long-Term Care on increasing compliance with the CPSO's policy on accepting new patients.

C21. The OHRC, where appropriate, will use its mandate to launch public interest inquiries, seek to intervene in cases, and/or launch Commission-initiated applications to actively challenge cases where doctors allegedly deny service delivery to people based on mental health or addiction disabilities.

C22. The OHRC will invite a provincial psychiatric institution, as well as other partners with human rights expertise in mental health, including consumer/survivor organizations, to engage in a large-scale organizational change process to address human rights concerns in service delivery to people with mental health disabilities, addictions, as well as other groups protected by the *Code*. Such a process may, among other things, involve a review of internal policies and practices, to identify and remove any discriminatory barriers.

C23. The OHRC will work with hospitals, the MOHLTC, consumer/survivor groups and other appropriate stakeholders to identify how to collect human rights-based data to measure disparities between *Code* groups in the use of seclusion, restraints and other relevant health care issues. Any data collection measures must ensure people's dignity and protect people's privacy.

C24. In its work with police services in Ontario, the OHRC will raise issues about discrimination against people with mental health or addiction disabilities in service delivery, and will work with police to build capacity to address these concerns.

C25. The OHRC, in its human rights work with the Ministry of Community Safety and Correctional Services (MCSCS), will include as a focus concerns about the lack of accommodation of people with mental health issues and addictions, particularly as these intersect with other *Code* grounds including race and related grounds, other forms of disability, and sex.

C26. The OHRC will continue to work with administrative tribunals in Ontario to provide training on human rights, including the duty to accommodate, where these relate to serving people with psychiatric disabilities and addictions, as well as other *Code*-protected groups.

Appendix 2: List of organizations that provided written submissions

Advocacy Centre for Tenants Ontario (ACTO)

Advocacy Centre for the Elderly (ACE)

ARCH Disability Law Centre (ARCH)

Canadian Auto Workers (CAW)

Canadian Life and Health Insurance Association

Canadian Mental Health Association Kawartha Lakes Branch

Canadian Mental Health Association Ontario Branch (CMHA Ontario)

Canadian Mental Health Association Sudbury-Manitoulin Branch

Centre for Addiction and Mental Health (CAMH)

Children's Hospital of Eastern Ontario (CHEO)

College of Physicians and Surgeons of Ontario (CPSO)

Empowerment Council

Federation of Rental Housing Providers of Ontario (FRPO)

French Language Health Services Network of Eastern Ontario (RSSFEO)

Horizons Renaissance

Lakehead District School Board, Special Education Advisory Committee

Landlord's Self-Help Centre

Learning Disorders Association of Ontario (LDAO)

Mary Ann Baynton and Associates Consulting

Metro Toronto Chinese and Southeast Asian Legal Clinic (MTCSALC)

Municipality of Chatham-Kent Health and Family Services

New Mennonite Centre

Nipissing Community Legal Clinic

Nipissing Mental Health Housing and Support Services

Ontario Association of Social Workers

Office of the Worker Advisor

Ontario Federation of Indian Friendship Centres (OFIFC)

Ontario Federation of Labour

Ontario Hospital Association (OHA)

Ontario Non-Profit Housing Association (ONPHA)

Ontario Nurses' Association

Ontario Public Service – HROntario (OPS)

Ontario Restaurant Hotel and Motel Association

Ontario Secondary School Teachers' Federation (OSSTF/FEESO)

Ontario Shores Centre for Mental Health Sciences (Ontario Shores)

People Advocating for Change through Empowerment (PACE)

Provincial Human Services and Justice Coordinating Committee (PHSJCC)

Psychiatric Patient Advocacy Office (PPAO)

Registered Nurses Association of Ontario (RNAO)

Royal Ottawa Health Care Group

Toronto Community Housing Corporation Anti-Ableism Committee

University of Guelph Human Rights Office

York Support Services Network & York Regional Police

Endnotes

BEGIN
"doors of perception"
ANALYZE THIS!
FRESH START
OPENING THE VAULT
You'll be happier.
habilitation saves life.
A wall of stone
JOY IS A TOUGH
QUESTIONS
over a new way
EXPERIENCE
The hidden powe
own unique situation."
Who the hell
REDISCOVER
YOU HOLD the CROWN
orld unfold
OF MIND
THE BODY
it's not the friends you meet, it's the friends you keep.
ESTYLE
thoughts
ARE
PEN MINDS, FREE SO
Be vigilant
AVE AN
ATTITUDE
a unique destination
THE
ocacy
TRANSFORMATION!
THINK TWICE
ievement
hope and a dream
thanks for the ride
MAKE A STATEMENT
"IT STILL FEELS LIKE THERE'S FOREVER TO GO. THERE ISN'T"
SPOKEN WORDS
MEMORY
PENS
YOU CAN DO IT
CARPE DIEM!
SOLVED
LINE
success story

Endnotes

[1] See *Battlefords and District Co-operative Ltd. v. Gibbs*, [1996] 3 S.C.R. 566; *Fleming v. Reid*, [1991] O.J. No. 1083, 1991 CanLII 2728 (ON CA) and *Granovsky v. Canada (Minister of Employment and Immigration)*, 1 SCR 703 at para 68.

[2] *R. v. Swain*, [1991] 1 SCR 933 at p. 973-4.

[3] The term consumer/survivor refers to bridging at least two ideologies. Historically, the term "consumer" has been used to describe an approach to the psychiatric system that reflected choice and input into treatment and improving services, whereas the term "survivor" or "psychiatric survivor" has been adopted by people in the anti-psychiatry movement as a reaction to the concept of mental illness and wanting to replace psychiatry with survivor-run alternatives. Geoffrey Reaume, "Lunatic to patient to person: Nomenclature in psychiatric history and the influence of patients' activism in North America" (2002) 25 Int. J. of Law and Psychiatry, 419-420. However, in using these terms, they may still apply to people who may have not sought help for mental health issues. Kathryn Church, *Forbidden Narratives: Critical Autobiography as Social Science* (New York: Gordon and Breach, 1995) at 12.

[4] S.O. 2005, c. 11.

[5] Letter from Chief Commissioner Barbara Hall to Charles Beer, AODA Review (October 30, 2009) regarding: Submission to the AODA review, online: Ontario Human Rights Commission www.ohrc.on.ca/en/resources/news/beer/view; In an independent review of the *AODA* in 2010, the reviewer, Charles Beer, heard from community stakeholders that the roll-out of the standards must be accompanied by substantial government investment to change the attitudinal barriers that limit opportunities for people with mental health and other disabilities. Charles Beer, *Charting a Path Forward: Report of the Independent Review of the Accessibility for Ontarians with Disabilities Act, 2005* (2010), online: Ministry of Community Social Services www.mcss.gov.on.ca/documents/en/mcss/accessibility/Charles%20Beer/Charles%20Beer.pdf at 20.

[6] Part of the 10-year mandate of the Mental Health Commission of Canada is to develop a national mental health strategy and work to diminish the stigma and discrimination faced by Canadians living with a mental illness and their families. Final report of the Standing Senate Committee on Social Affairs, Science and Technology, *Out of the Shadows at Last: Transforming Mental Health, Mental Illness and Addiction Services in Canada* (2006) at 438 (Chair: Michael J.L. Kirby); In June 2011, the provincial government released its mental health and addictions strategy, which identified reducing stigma and discrimination as part of creating healthy, resilient and inclusive communities. Government of Ontario, *Open Minds, Healthy Minds: Ontario's Comprehensive Mental Health and Addictions Strategy* (Toronto: Queen's Printer for Ontario, June 2011) at 12.

[7] See Lucy Costa, Jijian Voronka, Danielle Landry, Jenna Reid, Becky McFarlane, David Reville & Kathryn Church, "Recovering our Stories: A Small Act of Resistance" Studies in

Social Justice [forthcoming in Autumn 2012]; Kathryn Church, "In Whose Interests? Querying the Use of Stories in Narrative Research (Panel presentation given to "Recovering Our Stories: How Psychiatric Survivors Can Use Our Stories to Change the World", Ryerson University) (Toronto, 28 June 2011).

[8] See Law Commission of Ontario, *The law as it affects persons with disabilities. Preliminary consultation paper: Approaches to defining disability* (2009), online: Law Commission of Ontario www.lco-cdo.org.

[9] *Convention on the Rights of Persons with Disabilities*, 13 December 2006, U.N.T.S. vol. 2515, p.3 [*CRPD*], (entered into force 3 May 2008, accession by Canada 11 March 2010) online: Office of the United Nations High Commissioner for Human Rights www2.ohchr.org/english/law/disabilities-convention.htm at preamble (e).

[10] *CRPD, ibid.*, Article 1.

[11] *Quebec (Commission des droits de la personne et des droits de la jeunesse) v. Montreal (City); Quebec (Commission des droits de la personne et des droits de la jeunesse) v. Boisbriand (City)*, [1999] 1 S.C.R. 381.

[12] Several types of definitions exist for "mental health issues." One definition supplies a bio-medical approach. In the Government of Canada's 2006 report, *The Human Face of Mental Health and Mental Illness in Canada*, "mental health issues" are referred to as, "Alterations in thinking, mood or behaviour or some combination thereof, that are associated with significant distress and impaired functioning" (Ottawa: Minister of Public Works and Government Services Canada, 2006) at 2. However, as stated previously, mental health issues are not barriers in and of themselves. Society can create barriers through inaccessible information or communications as well as through attitudes. Barriers may exist because of interactions between the environment and a person's personal experience of impairment.

[13] Subsections 10(1) (d) and (b) of the *Code*.

[14] The OHRC recognizes that different forms of addiction, such as alcohol and drug dependencies, have been found to be disabilities within the meaning of the *Code*. The Standing Senate Committee on Social Affairs, Science and Technology notes that, "Addiction implies uncontrollable use of one or more substances, associated with discomfort or distress when that use is discontinued or severely reduced. Addiction may also describe certain other behavioural problems, such as compulsive or pathological gambling, which can be considered a process rather than a substance addiction." (Interim Report of the Standing Senate Committee on Social Affairs, Science and Technology, *Report 1: Mental Health, Mental Illness and Addiction: Overview of Policies and Programs in Canada* (2004) at 74 (Chair: Michael J.L. Kirby). However, as described in the note above, barriers in society can create or aggravate the experience of disability for someone with an addiction.

[15] In Ontario, 4.8% of adults (449,000 people) have moderate or severe gambling problems. An additional 9.6% (860,000 people) are classified as "at-risk" for problem gambling. "Info on Problem Gambling," online: The Centre for Addiction and Mental Health www.camh.net/About_Addiction_Mental_Health/AMH101/top_searched_prob_gambling.html>.

[16] *Ontario (Disability Support Program) v. Tranchemontagne*, 2010 ONCA 593 (CanLII).

[17] The Law Commission of Ontario posits that, "to some degree, the differences in approaches to addictions [in human rights law] may reflect perceptions that these conditions involve a degree of voluntariness that is not invoked in other types of disability – that is, there is no true impairment." Law Commission of Ontario, *supra* note 8 at 34.

[18] A large US epidemiological study found that 37% of people with an alcohol disorder had at least one mental disorder and 21.5% had another drug dependence disorder. For people with a lifetime history of drug abuse dependence, 53.1% also had a mental disorder. Darrel A. Regier, *et al.*, "Comorbidity of Mental Disorders With Alcohol and Other Drug Abuse: Results From the Epidemiologic Catchment Area (ECA) Study" (1990) 264:19 J.A.M.A. 2511.

[19] Geoffrey Reaume, "Lunatic to patient to person: Nomenclature in psychiatric history and the influence of patients' activism in North America" (2002) 25 Int. J. of Law and Psychiatry 405.

[20] Law Commission of Ontario, *supra* note 8 at 16.

[21] Geoffrey Reaume, *supra* note 19.

[22] Human Resources and Skills Development Canada, *A Way with Words and Images: Suggestions for the Portrayal of People with Disabilities* (Ottawa: Her Majesty the Queen in Right of Canada, 2006) at 11.

[23] World Network of Users and Survivors of Psychiatry, *Implementation manual for the United Nations Convention on the Rights of Persons with Disabilities* (February 2008), online: World Network of Users and Survivors of Psychiatry www.wnusp.net/UnitedNations_MMtmp03630c55/UnitedNationsConventionfortheRightsofPersonswithDisabilities.htm at 9.

[24] In keeping with the decision of the Supreme Court of Canada in *Andrews* v. *Law Society of British Columbia*, [1989] 1 S.C.R. 143 at 174, discrimination in a social area may be described as any distinction, conduct or action, whether intentional or not, but based on a *Code* ground, that creates disadvantage by perpetuating prejudice or stereotyping. In most human rights cases, if a distinction based on a prohibited ground that creates a disadvantage is shown to exist, it is not necessary to have independent evidence of stereotyping or of prejudice; *Ontario Disability Support Program* v. *Tranchemontagne, supra* note 16.

[25] See also *British Columbia (Public Service Employee relations Comm.) v. BCGSEU*, [1999] 3 S.C.R. 3 [Meiorin].

[26] Under section 7 of the *Charter*, people cannot be deprived of these rights except according to the principles of fundamental justice.

[27] *Health Care Consent Act, 1996* S.O. 1996 c. 2, Sched. A.

[28] An Ontario Court has confirmed that rights under the *Mental Health Act* must be taken to conform to similar rights under sections 9 and 10(b) of the *Charter; R. v. Webers*, 1994 CanLII 7552 (ON SC) at para. 31. The Court cited with approval a Review Board decision which noted "…the *Mental Health Act* is replete with procedural safeguards. The safeguards have been implemented in recognition of the fact that a patient who is detained under the authority of the *Mental Health Act* or who loses control over his or her own treatment or assets has been deprived of their liberty, autonomy or right to self-determination no less than an individual who has been imprisoned."

[29] *CRPD, supra* note 9, Article 1.

[30] *Baker v. Canada* (Minister of Citizenship and Immigration), [1999] 2 S.C.R., para. 69

[31] *Baker, ibid* at para. 70; The UN has said that ratifying the *CRPD* creates a "strong interpretive preference in favour of the Convention. This means that the judiciary will apply domestic law and interpret legislation in a way that is as consistent as possible with the Convention." UN, *From Exclusion to Equality: Realizing the Rights of Persons with Disabilities: Handbook for Parliamentarians on the Convention on the Rights of Persons with Disabilities and its Optional Protocol* (Geneva: United Nations, 2007) at 107.

[32] "Stigma" is a term used to capture a number of different concepts relating to mental health and addictions. Link and Phelan define stigma in terms of, "the convergence of interrelated components." Stigma exists when elements of labelling, stereotyping, separation, status loss and discrimination occur together in a power situation that allows them. Bruce G. Link and Jo C. Phelan, "Conceptualizing Stigma" (2001) 27 Annul. Rev. Sociol 377.

[33] Law Commission of Ontario, *Advancing Equality for Persons with Disabilities Through Law, Policy and Practice: A Draft Framework* (March 2012) at 3.

[34] For example, the term "sanism" has been used to describe how the community and the legal system in particular have an "irrational prejudice" towards people based on mental disability. Michael Perlin, "International Human Rights and Comparative Mental Disability Law: the Use of Institutional Psychiatry as a Means of Suppressing Political Dissent" (2006) 39 Isr. L.R. 69 72.

[35] The risk of violence has been documented to be higher when people with serious mental illnesses also use substances; however, CMHA Ontario reports that rates of violence among individuals with mental illness without concurrent substance use tend to be similar to the rates of violence in the general public. People with serious mental health issues are more likely to be victims of violence than the general population. Canadian Mental Health Association, Ontario, *Violence and Mental Health: Unpacking a Complex Issue. A discussion paper* (September 2011), online: Canadian Mental Health Association, Ontario www.ontario.cmha.ca/backgrounders.asp?cID=1081747.

[36] CMHA Ontario recommends that the media refer to the guidelines on responsible media coverage developed by organizations like the Canadian Psychiatric Association and the Centre for Addiction and Mental Health, *ibid*., at 10.

[37] According to a 2008 Ipsos Reid poll of over 1000 Canadians, almost half (46%) of respondents felt that the term "mental illness" is used as an excuse for bad behaviour (Canadian Medical Association, 8th Annual National Report Card on Health Care (2008) online: Canadian Medical Association www.cma.ca/multimedia/CMA/Content_Images/Inside_cma/Annual_Meeting/2008/GC_Bulletin/National_Report_Card_EN.pdf at 4.

[38] Gerald B. Robertson, "Mental Disability and Canadian Law" (1993) 2:1 Health L. Rev. 23; Standing Senate Committee on Social Affairs, Science and Technology, *supra* note 6 at 40.

[39] For example, a psychiatric model of addiction which was popular between the 1940s and 1970s attributed the individual's addiction to personality "flaws." Caroline J. Acker, "Stigma or legitimation? A Historical Examination of the 27 Social Potentials of Addiction Disease Models" (1993) 25:3 J. of Psychoactive Drugs 202, as cited by Centre for Addiction and Mental Health, *The Stigma of Substance Abuse: A Review of the Literature* (18 August 1999) at 7.

[40] Neasa Martin & Valerie Johnston, *A Time for Action: Tackling Stigma and Discrimination: Report to the Mental Health Commission of Canada* (2007) at 11.

[41] *Ibid*., at 17. In addition, in recent years, there has also been a commitment by public and private organizations to engage in broad anti-stigma campaigns to educate the public about mental health issues, including Bell Canada and the Mental Health Commission of Canada. The *Globe and Mail* also created a series about mental health.

[42] *Ibid*., at 17.

[43] To determine respondents with "emotional" disabilities, PALS survey respondents answered the following question: Do you (Does (…) have any emotional, psychological or psychiatric conditions that have lasted, or are expected to last, six months or more? These include phobias, depression, schizophrenia, drinking or drug problems and others.

Statistics Canada, *Participation and Activity Limitation Survey – 2006 (Adults 15 years or older)* (2006) online: Statistics Canada www5.statcan.gc.ca/access_acces/alternative_alternatif.action?l=eng&loc=http://www23.statcan.gc.ca:81/imdb-bmdi/instrument/3251_Q2_V2-eng.pdf&teng=Participation%20and%20Activity%20Limitation%20Survey%20-%202006%20(Adults%20-%2015%20and%20over)&tfra=Enquête%20sur%20la%20participation%20et%20les%20limitations%20d'activités%20-%202006%20(Adultes%20-%2015%20ans%20et%20plus).

[44] Statistics Canada, in its PALS data provided to the OHRC, defines low income as, "Member of low income economic family or low income unattached individual (after tax)."

[45] For a review of the research, see *Registered Nurses Association of Ontario, Creating Vibrant Communities: RNAO's Challenge to Ontario's Political Parties 2011 Provincial Election, Technical Backgrounder*, (Toronto: RNAO, 2010) online: RNAO www.rnao.org/Storage/65/5964_Backgrounder.pdf, at 9; In several decisions, the Human Rights Tribunal of Ontario, as well as the Courts, have recognized the connection between membership in a group identified under the *Code* and the likelihood of having low income: see, for example, *Kearney v. Bramalea Ltd. (No. 2)*, (1998), 34 C.H.R.R. D/1 (Ont. Bd. Inq.).

[46] *Concluding observations of the Committee on Economic, Social and Cultural Rights: Canada* ESC 1-19 May 2006, UN ESCOR, 36th Sess., UN docs. E/C.12/CAN/CO/4 & E/C.12/CAN/CO/5, online: United Nations www.unhchr.ch/tbs/doc.nsf/0/87793634eae60c00c12571ca00371262/$FILE/G0642783.pdf at para.15.

[47] *CRPD, supra* note 9, Article 28(2) a-e.

[48] S.O. 2009, c.10

[49] Section 2(2) of the Act, Principle 3. Section 5(2).

[50] In its initial 2012 budget proposal, the Government of Ontario did not propose any increases in social assistance rates, and delayed increases to the Ontario Child Benefit. *Strong Action for Ontario, 2012 Ontario Budget, Budget Papers* (Toronto: Queen's Printer for Ontario, 2012), at 44-45. At the time of writing this report, the final provincial budget has not been passed. Several reports comment on the link between decreased funding to services, poverty reduction and the impacts on the health and food security of low-income Ontarians. See Wellesley Institute, *Ontario Budget 2012: Austerity is bad for our Health*, 2012, online: Wellesley Institute www.wellesleyinstitute.com/wp-content/uploads/2012/03/Ontario-budget-2012-Austerity-is-bad-for-our-health-Will-the-budget-avoid-harm-to-children-lowincome-ontarians-and-women1.pdf; 25 in 5 Network for Poverty Reduction, *Common Ground: A Strategy for Moving Forward on Poverty Reduction. Third Annual Progress Report on Poverty Reduction in Ontario* (December 2011), online: 25 in 5 25in5.ca/wp-content/uploads/2011/12/25-in-5-Common-Ground-final.pdf at 5; Social Planning Network of Ontario, *A recovery-free zone: the unyielding impact of the economic downturn on non-profit community social services in Ontario* (July 2010) at 5; Social Planning Network on Ontario, Hard hit: Impact of the Economic Downturn on Nonprofit Community Social Services in Ontario (October 2009).

[51] In their second discussion paper, the Commission for the Review of Social Assistance in Ontario stated that of the 27,600 ODSP applications granted in 2009-10, about 60% involved a mental illness as either a primary or secondary condition. Commission for the Review of Social Assistance in Ontario, *Discussion Paper 2: Approaches for Reform* (Toronto: Queen's Printer for Ontario, February 2012) at 9.

[52] World Health Organization, *Mental Health and Development: Targeting People with Mental Health Conditions as a Vulnerable Group* (2010) online: World Health Organization www.who.int/mental_health/policy/mhtargeting/en/index.html at xxv-xxvi.

[53] World Health Organization, WHO Resource Book on Mental Health, Human Rights and Legislation (Geneva: World Health Organization, 2005) as cited by Ontario Federation of Mental Health and Addiction Programs, *Embracing Cultural Competence in the Mental Health and Addiction System* (June 2009) online: OFMHAP www.ofcmhap.on.ca/sites/ofcmhap.on.ca/files/CulturalCompetwC%20(4).pdf at 24; Juha Mikkonen & Dennis Raphael, *Social Determinants of Health: The Canadian Facts* (Toronto: York University School of Health Policy and Management, 2010) online: The Canadian Facts www.thecanadianfacts.org/The_Canadian_Facts.pdf at 9; Mental Health Commission of Canada Diversity Task Group, *Improving Mental Health Services for Immigrant, Refugee, Ethno-cultural and Racialized Groups – Issues and Options for Service Improvement* (12 November 2009) online: Mental Health Commission of Canada www.mentalhealthcommission.ca/SiteCollectionDocuments/Key_Documents/en/2010/Issues_Options_FINAL_English%2012Nov09.pdf at 15.

[54] Although definitions vary, cultural competence refers in part to "the level of knowledge based skills required to provide meaningful, supportive and respectful service delivery to clients from various marginalized groups in society ..." Key principles of cultural competence include inclusiveness, holistic health, anti-oppression and valuing diversity. Zine, in progress, as cited by Ontario Federation of Mental Health and Addiction Programs, *Embracing Cultural Competence in the Mental Health and Addiction System* (June 2009) online: Ontario Federation of Mental Health and Addiction Programs www.ofcmhap.on.ca/sites/ofcmhap.on.ca/files/CulturalCompetwC%20(4).pdf at 22.

[55] Kwasi Kafele, *Racial Discrimination and Mental Health: Racialized and Aboriginal Communities* (December 2004), Submitted to the OHRC Race Policy Dialogue, online: OHRC www.ohrc.on.ca/en/issues/racism/racepolicydialogue/kk/view at 13.

[56] Kwasi Kafele, *Racism and Mental Health: A compendium of Issues, Impact and Possibilities* (2006). Resource provided to the OHRC.

[57] People with a psychiatric disability as well as a physical disability tend to report more perceived stigma and discrimination overall, and in the areas of lack of housing, poverty and neighbourhood of residence. Allison Bahm & Cheryl Forchuk, "Interlocking oppressions: The Effect of a Co-morbid Physical Disability on Perceived Stigma and Discrimination among Mental Health Consumers in Canada" (2008) 17:1 *Health and Social Care in the Community* 63.

[58] Allen M. Omoto & Howard S. Kurtzman, eds., *Sexual Orientation and Mental Health: Examining Identity and Development in Lesbian, Gay and Bisexual people* (Washington, DC: APA Books, 2006); S.D.Cochran, J.G. Sullivan, & V.M. Mays, "Prevalence of Mental Disorders, Psychological Distress, and Mental Health Services Use among Lesbian, Gay, and Bisexual Adults in the United States," (2003) 71 J. of Consulting and Clinical Psychology 53; I.Meyer, "Prejudice, Social Stress, and Mental Health in Lesbian, Gay, and Bisexual Populations: Conceptual Issues and Research Evidence" (2003) 129 Psychological Bulletin 674; as cited by W.B. Bostwick, *Mental Health Issues among Gay, Lesbian Bisexual and Transgender (GLBT) People*, (National Alliance on Mental Illness: 2007) online: NAMI www.nami.org/TextTemplate.cfm?Section=Fact_Sheets1&Template=/ContentManagement/ContentDisplay.cfm&ContentID=54036, retrieved 5 August 2009.

[59] For a review of the literature, see Dean L, *et al.*, "Lesbian, Gay, Bisexual, and Transgender Health: Findings and Concerns" (2000) 4:3 J. of the Gay and Lesbian Medical Association 101.

[60] Elizabeth Saewyc *et al.*, Not Yet Equal: *The Health of Lesbian, Gay, & Bisexual Youth in BC* (Vancouver, BC: The McCreary Centre Society, 2007) at 31.

[61] Ad hoc working group on women, mental health, mental illness and addictions, *Women, Mental health, Mental Illness and Addictions in Canada: An Overview* (2006) online: Canadian Women's Health Network www.cwhn.ca at 25.

[62] Moira Welsh & Jesse McLean, "Nursing home residents abused" *Toronto Star*, (17 November 2011), online: The Toronto Star www.thestar.com; Moira Welsh, "Task force gets cracking on troubled nursing home system" Toronto Star (1 February 2012) online: The Toronto Star www.thestar.com.

[63] Barbara Ehrenreich & Deirdre English, *For Her Own Good: 150 Years of Experts' Advice to Women, (Garden City, NY: Anchor Books, 1978)*, as cited by the Ad hoc working group on women, mental health, mental illness and addictions, *supra* note 61 at 1.

[64] Kyle Scanlon, *et al.*, "Ontario's Trans Communities and Suicide: Transphobia is Bad for Our Health," *Trans PULSE E-Bulletin* 1:2 (12 November 2010), online: Transpulse project transpulseproject.ca/documents/E2English.pdf.

[65] Race is a social construct. The Report of the Commission on Systemic Racism in the Ontario Criminal Justice System defined racialization "as the process by which societies construct races as real, different and unequal in ways that matter to economic, political and social life." Ontario Human Rights Commission, *Policy and Guidelines on Race and Racial Discrimination* (Toronto: Queen's Printer for Ontario, 2005) at 11.

[66] A study conducted in Montreal also found that African-Canadians were overrepresented in police referrals to emergency psychiatric services. G. Eric Jarvis, *et al.* "The Role of Afro-Canadian Status in Police or Ambulance Referral to Emergency Psychiatric Services" (2005) 56:6 Psychiatric Services 705.

[67] Research from the US and the UK, and some from Canada, has supported that people of African or Caribbean descent, particularly men and people who are immigrants, are disproportionately likely to be represented in the mental health and forensic mental health system and diagnosed with psychosis or schizophrenia, although multiple contributing factors need to be considered. One report states, "there are no statistics available, but psychiatric forensic units in Southwestern Ontario (including CAMH), based on anecdotal information, seem to have a disproportionately high number of men of colour, including African-Canadian men." Pascale C. Annoual, Gilles Bibeau, Clem Marshall & Carlo Sterlin, *Enslavement, Colonialism, Racism, Identity and Mental Health: Developing a new service model for Canadians of African Descent. Phase I report* (Toronto: CAMH, 2007) online: Centre for Addiction and Mental Health www.camh.net/publications/resources_for_professionals/EACRIMH/eacrimh_report1107.pdf at 13; G. Eric Jarvis, *et al.* "High rates of psychosis for black inpatients in Padua and Montreal: Different Contexts, Similar Findings" (2011) 46 Soc. Psychiatri. Epidemiol. 247; Kwame McKenzie & K. Bhui, "Institutional Racism in Mental Health Care" (Mar 2007) 334 B.M.J.649.

[68] G. E. Jarvis, *Emergency Psychiatric Treatment of Immigrants with Psychosis*, (Master of Science in Psychiatry, Department of Psychiatry, McGill University, Faculty of Medicine, 2002) [unpublished] at 91; Amos Bennewith, *et al.* "Ethnicity and Coercion among Involuntarily Detained Psychiatric In-patients" (2010) 196 British J. of Psychiatry 75; Rachel Spector, "Is There Racial Bias in Clinicians' Perceptions of the Dangerousness of Psychiatric Patients? A Review of the Literature" (2001) 10:1 J. of Mental Health 5.

[69] See Ontario Human Rights Commission, *Policy on Discrimination and Language* (Toronto: Queen's Printer for Ontario, 1996), online: OHRC www.ohrc.on.ca/en/resources/Policies/lang/view.

[70] Seventy-seven percent of Francophone people in Ontario have no or rare access to alcohol treatment centres in French; 66% have no or rare access to drug addiction centres in French and 53% have no or rare access to mental health services (excluding psychiatric hospitals) in French. Office of the French Language Services Commissioner,

Special Report on French Language Health Services Planning in Ontario (Queen's Printer for Ontario, 2009) at 8, as cited by the submission by the French Language Health Services Network of Eastern Ontario.

[71] National Council of Welfare, *First Nations, Métis and Inuit Children and Youth: Time to Act* 127 (Ottawa: Her Majesty the Queen in Right of Canada, 2007) at 64.

[72] Jeff Latimer & Laura Casey-Foss, *A One-Day Snapshot of Aboriginal Youth in Custody across Canada: Phase II*, (Ottawa: Department of Justice Canada, Youth Justice Research, February 2004) at iii.

[73] D. Jeste, *et al*, "Consensus statement on the upcoming crisis in geriatric mental health: Research agenda for the next two decades" (1999) 56 Archives of General Psychiatry 848, as cited by the submission from ACE.

[74] ACE said that according to the Canadian Institute for Health Information, in 2006-2007, 37.7% of residents in long-term care homes on public drug programs were prescribed antipsychotic medication versus only 2.6% of older adults living in the community who could claim anti-dementia drugs. The study stated, "The higher rate of antipsychotic use among seniors using anti-dementia drugs in nursing homes may suggest that there are factors in addition to differences in the prevalence of dementia that contribute to variation in the rates of antipsychotic use." Canadian Institute for Health Information, *Antipsychotic Use in Seniors: An Analysis Focusing on Drug Claims, 2001 to 2007* (2009), online: Canadian Institute for Health Information http://secure.cihi.ca/cihiweb/products/antipsychotics_aib_en.pdf at 15.

[75] Andrea Davis, "DM Diagnostic" (1 March 2006), online: Benefits Canada www.benefitscanada.com/news/dm-diagnostic-8220, retrieved May 3, 2012; David Brown, *CIBC's Disability Management Principles* [unpublished slide presentation].

[76] A household is in core housing need if its housing fails to meet at least one of three standards established for housing: adequacy (in need of major repair), suitability (fewer bedrooms than required) and affordability (it costs 30% or more of household before-tax income); and if its income before taxes is at or below the appropriate community-and-bedroom specific income threshold. Statistics Canada, *Participation and Activity Limitations Survey, 2006: Selected Variables by Emotional Disability, Other Disabilities and No Disability for Canada and Ontario, 2006*. Data provided to the OHRC.

[77] Douglas A. Steinhaus, Debra A. Harley & Jackie Rogers, "Homelessness and People with Affective Disorders and Other Mental Illnesses" (2004) 35 J. Applied Rehabilitation Counseling 36; For a review of precarious housing and health impacts, see Wellesley Institute, *Precarious Housing in Canada* (2010) online: Wellesley Institute www.wellesleyinstitute.com/wp-content/uploads/2010/08/Precarious_Housing_In_Canada.pdf; Rahel Eynan, *et al*. "The Association Between Homelessness and Suicidal Ideation and Behaviours: Results of a Cross-Sectional survey" (2002) 32 Suicide and Life-Threatening Behavior 418.

[78] Concluding Observations of the Human Rights Committee: Canada, UN ESCOR, 2006, UN Doc. CCPR/C/CAN/CO/5. at para 17.

[79] Cheryl Forchuk et al., "From Psychiatric Ward to the Streets and Shelters" (2006) 13:3 J. of Psychiatric & Mental Health Nursing 301.

[80] For more information on this topic, see Ontario Human Rights Commission, *Human Rights and Rental Housing in Ontario: Background Paper* (Toronto: Queen's Printer for Ontario, 2007) online: OHRC www.ohrc.on.ca/en/resources/news/housingback.

[81] Ministry of Municipal Affairs and Housing, Media Release, "Affordable Housing boosted by New Legislation" (19 April 2011) online: Government of Ontario http://news.ontario.ca/mah/en/2011/04/affordable-housing-boosted-by-new-legislation.html.

[82] Ontario Non-Profit Housing Association, Media Release, "ONPHA Comments on Housing Strategy: Strategy Recognizes Importance of Community-Based Housing for Ontario's Future" (29 November 2010), online: ONPHA www.onpha.on.ca/AM/Template.cfm?Section=Long_Term_Affordable_Housing_Strategy&Template=/CM/ContentDisplay.cfm&ContentID=8897; Housing Network of Ontario, "Ontario's proposed affordable housing plan fails to meet the five basic tests set by the Housing Network of Ontario" (30 November 2010), online: Canadian News Wire http://cnw.ca/5LX9.

[83] Ontario Human Rights Commission, *Right at Home: Report on the consultation on human rights and rental housing in Ontario* (Toronto: Queen's Printer for Ontario, 2008) at 63.

[84] Ontario Non-Profit Housing Association, "Glossary of Terms and Acronyms" online: Ontario Non-Profit Housing Association http://onpha.on.ca/AM/Template.cfm?Section=Glossary, retrieved December 14, 2011.

[85] Patrick J. LeSage, *Report on the Eviction of Al Gosling and the Eviction Prevention Policy of Toronto Community Housing Corporation* (May 2010) online: Toronto Community Housing Corporation www.torontohousing.ca/webfm_send/6512/1?# at 5.

[86] John Sylvestre et al., "Strengthening Ontario's System of Housing for People with Serious Mental Illness" (2007) 26:1 Can. J. of Comm. Mental Health 79 at 82.

[87] *Housing Services Act, 2011*, S.O. 2011, c. 6, Sched. 1, O.Reg. 367/11, s. 24. The *Housing Services Act, 2011* replaced the *Social Housing Reform Act, 2000*.

[88] *Housing Services Act, 2011, ibid.* O. Reg. 298/01 (formerly under *Social Housing Reform Act, 2000*). Sections 48(5) and 48(6) state that if monthly non-benefit income exceeds a certain amount per month (based on the size of the benefit unit), the monthly rent can exceed the amount otherwise stipulated.

[89] John Stapleton, *Why is it so Tough to Get Ahead: How Our Tangled Social Programs Pathologize the Transition to Self-Reliance* (Metcalf Foundation, 2007) at 29; John Stapleton, *Zero Dollar Linda: A Meditation on Malcolm Gladwell's "Million Dollar Murray," the Linda Chamberlain Rule, and the Auditor General of Ontario* (Metcalf Foundation, November 2010) online: Metcalf Foundation www.metcalffoundation.com/wp-content/uploads/2011/05/zero-dollar-linda.pdf.

[90] Bill 198, the *Planning Amendment Act (Enabling Municipalities to Require Inclusionary Housing), 2009*, which included sections on inclusionary zoning, was referred to the Standing Committee on General government on September 24, 2009, but did not go through third reading.

[91] In a study done by the Centre for Equality Rights in Accommodation, it estimated that one in three house-seekers who disclose a mental illness will experience discrimination in the Toronto rental housing market. Centre for Equality Rights in Accommodation, *Sorry It's Rented: Measuring Discrimination in Toronto's Rental Housing Market* (July 2009) online: CERA www.equalityrights.org/cera. Thirty-four percent of respondents taking part in the Senate Standing Committee's e-consultation reported that they or people they knew had been turned down for a job or fired because of a mental illness, and 21% had been denied housing by a landlord. Howard Chodos, N. Pogue & T. Riordan, *E-consultation on mental health, mental illness and addiction: Phase one* (Parliamentary Information and Research Service, Library of Parliament, 2005) as cited in the Standing Senate Committee on Social Affairs, Science and Technology, *supra* note 14 at 228.

[92] *Meiorin, supra* note 25.

[93] Sam Tsemberis, Leyla Gulcur & Maria Nakae, "Housing First, Consumer Choice, and Harm Reduction for Homeless Individuals With a Dual Diagnosis" (2004) 94:4 Am. J. Public Health 651; Mental Health Commission of Canada, *At Home/Chez Soi Early Findings Report Volume 2* (January 2012) Online: MHCC www.mentalhealthcommission.ca/SiteCollectionDocuments/News/At%20Home_EarlyFindingsReportVolume2_ENG.pdf;

the Mental Health Commission of Canada's National Mental Health Strategy recommends the use of "housing first" strategies to address homelessness. Mental Health Commission of Canada, *Changing Directions, Changing Lives: The Mental Health Strategy for Canada* (2012), Recommendation 3.5.2 at 75.

[94] *Residential Tenancies Act, 2006*, S.O. 2006, c. 17, s. 64. (1) A landlord may give a tenant notice of termination of the tenancy if the conduct of the tenant, another occupant of the rental unit or a person permitted in the residential complex by the tenant is such that it substantially interferes with the reasonable enjoyment of the residential complex for all usual purposes by the landlord or another tenant or substantially interferes with another lawful right, privilege or interest of the landlord or another tenant.

[95] For example, some social housing providers such as the Toronto Community Housing Corporation and City Housing Hamilton have established "mental health frameworks," human rights and harassment policies, eviction prevention procedures, or other resources for vulnerable tenants. These must be applied consistently and to be effective, staff should be trained on them. Patrick J. LeSage, *Report on the Eviction of Al Gosling and the Eviction Prevention Policy of Toronto Community Housing Corporation* (May 2010) online: Toronto Community Housing Corporation www.torontohousing.ca/webfm_send/6512/1?#> at 6, 26 & 27.

[96] *CRPD, supra* note 9, Article 27(1)(a),(b), and (e).

[97] Statistics Canada, *Participation and Activity Limitation Survey* (2006). Data provided to the OHRC.

[98] Standing Senate Committee on Social Affairs, Science and Technology, *supra* note 14 at 50.

[99] Statistics Canada, *Participation and Activity Limitation Survey of 2006: Labour Force Experience of People with Disabilities in Canada* (2010) online: Statistics Canada www.statcan.gc.ca/pub/89-628-x/89-628-x2008007-eng.htm#a2; Michael Mendelson, Ken Battle, Sherri Torjman & Ernie Lightman, *A Basic Income Plan for Canadians with Severe Disabilities*, (The Caledon Institute of Social Policy, 2010) at 3; Canadian Mental Health Association Ontario and Centre for Addiction and Mental Health, *Education and Employment for people with mental illness: Discussion Paper* (January 2010) online: Centre for Addiction and Mental Health www.camh.net/Public_policy/Public_policy_papers/employment_discussion_paper_jan10.pdf.

[100] Roeher Insitute, *Improving the Odds: Employment, Disability and Public Programs in Canada*, 2004 at 49-50, as cited by Law Commission of Ontario, *Submission of the Law Commission of Ontario to the Commission for the Review of Social Assistance in Ontario* (29 August 2011) online: Law Commission of Ontario www.lco-cdo.org at 6.

[101] Canadian Mental Health Association Ontario and Centre for Addiction and Mental Health, *supra* note 99 at 3.

[102] See, for example, Isabel Teotonio, "Canadian woman denied entry to U.S. because of suicide attempt" *Toronto Star* (29 January 2011) online: *Toronto Star* www.thestar.com/news/article/930110--canadian-woman-denied-entry-to-u-s-because-of-suicide-attempt.

[103] Ontario Association of Chiefs of Police, *LEARN Guideline for Police Record Checks* (28 March 2011) Online: Ontario Association of Chiefs of Police www.oacp.ca/upload5/news/GUIDELINES_FOR_RECORD_CHECKS___FINAL.pdf.

[104] Some outstanding issues with the guidelines remain (for more information, please see the OHRC's letter to the OACP at www.ohrc.on.ca). In addition, the guideline created by the OACP is not binding and more education and promotion may need to take place to make sure that police services across Ontario implement consistent practices.

[105] Mental Health Commission of Canada, "Ontario Association of Chiefs of Police releases new guidelines for Police Record Checks" online: Mental Health Commission of Canada www.mentalhealthcommission.ca/English/Pages/Police_Record_Checks.aspx retrieved on January 9, 2012.

[106] In a study of over 1,000 Canadian employees and managers, only 36% of employees indicated that they would feel comfortable talking to their manager about a mental health issue. Over half of employees (54%) feared that their opportunities for promotion would be negatively affected, and 38% felt it would hamper their success. Karla Thorpe, "Building Mentally Healthy Workplaces: Perspectives of Canadian Workers and Front-Line Managers" (Presentation given at the Symposium on Stress, Mental Health, and the Workplace, Ryerson University, 30 September 2011), (2011) Conference Board of Canada.

[107] *Occupational Health and Safety Act*, R.S.O. 1990, c.O.1, ss.32.0.5(3), (4).

[108] A similar concern was raised in a human rights case before the Human Rights Tribunal of Ontario. Ms Trozzi argued that conditions that were attached to her nursing licence by the College of Nurses because of her disabilities, which included depression, were discriminatory. However, the Divisional Court found that the Tribunal could not hear the case as Ms Trozzi's concerns with the conditions that had been attached to her licence had already been "appropriately dealt with" in her appeal to the Health Professions Appeal and Review Board; *College of Nurses v. Trozzi*, 2011 ONSC 4614 (CanLII).

[109] Mental Health Works, "Cubicle bullies: 'Mobbing' at work," online: Mental Health Works www.mentalhealthworks.ca/media/mobbing-at-work retrieved on January 11, 2012. Mobbing can affect all employees, regardless of disability; "Mobbing" is "hostile and unethical communication [that] is directed in a systematic way by one or a number of persons mainly toward one individual ... These actions take place often (almost every day) and over a long period of time (at least for six months) and, because of this frequency and duration, result in considerable psychic, psychosomatic and social misery." Heinz Leyman, "Mobbing and psychological terror at workplaces" (1990) 5:2 Violence and Victims 119.

[110] Sections 14 and 24 of the *Code*, respectively.

[111] Ministry of Health and Long-Term Care, "Mental Health: Making it Work: Policy framework for employment supports for people with serious mental illness", online: Ministry of Health and Long-Term Care www.health.gov.on.ca/english/public/pub/mental/pfes.html. Appendix 2. Retrieved on January 12, 2012.

[112] Mary O'Hagan, Heather McKee & Robyn Priest, *Consumer Survivor Initiatives in Ontario: Building for an Equitable Future*, (Ontario Federation of Community Mental Health and Addiction Programs, 2009) at 14.

[113] Under the federal *Employment Equity Act*, S.C. 1995, c. 44, federally regulated employers (under the Employment Equity Program) and provincially regulated employers (under the Federal Contractors Program) must take steps to remove barriers to employment for the designated groups: women, Aboriginal peoples, persons with disabilities and members of "visible minorities."online: Human Resources Social Development Canada www.hrsdc.gc.ca/eng/labour/equality/employment_equity/act_mandates/index.shtml

[114] Sherry Mead, D. Hilton, & L. Curtis, "Peer support: A theoretical perspective" (undated), as cited in the Standing Senate Committee on Social Affairs, Science and Technology, *supra* note 6 at 234-235. Other kinds of employment supports include vocational assessment/planning programs, employment placement programs, and agency-sponsored businesses. Ministry of Health and Long-Term Care, "Mental Health:

Making it Work: Policy framework for employment supports for people with serious mental illness", online: Ministry of Health and Long-Term Care www.health.gov.on.ca/english/public/pub/mental/pfes.html. Appendix 2. Retrieved on January 12, 2012.

[115] Letter from Councilor Gord Perks, Chair of the Toronto Drug Strategy Implementation Panel, to Ms. Jann Houston, Director of Healthy Living/Healthy Communities, Toronto Public Health (12 October 2011).

[116] Mary O'Hagan, Heather McKee & Robyn Priest, *supra* note 112 at 33.

[117] *Employment Standards Act, 2000*, S.O. 2000, c. 41. Section 3(5)6. states that the *Act* does not apply to an individual who performs work in a simulated job or working environment if the primary purpose in placing the person in the job or environment is his or her rehabilitation.

[118] Carolyn S. Dewa, "Chronic Work Stress, Mental Disorder and Work Disability" (Presentation given at the Symposium on Stress, Mental Health, and the Workplace, Ryerson University, 30 September, 2011).

[119] Sections 13(4) and (5) of the *Workplace Safety and Insurance Act*, 1997, S.O. 1997, c. 16.

[120] Traditionally, benefits had only been available when a claimant experienced a traumatic event which presented a real or implied threat to the person's physical well-being. Because of an unfounded accusation that she assaulted a student, an Educational Assistant experienced a disabling psychological injury diagnosed as major depression. However, the claim was denied because it did not meet the Workplace Safety and Insurance Board's policy criteria, which appeared to limit entitlement to sudden and unexpected workplace events that threaten a person's physical well-being. On appeal, the WSIAT noted that the legislation does not appear to limit entitlement to events that are threatening to a person's physical well-being. It adjourned the hearing to receive submissions from the Board on the apparent inconsistency between its policy and the Act as well as inconsistencies in the policy itself. In response to the Tribunal's request, the Board advised that a real or implied threat to a person's physical well-being is not required to find entitlement to traumatic mental stress benefits. The Board also clarified that Post Traumatic Stress Disorder is not the only DSM-IV diagnosis that can form the basis for entitlement; any Axis I diagnosis may suffice. After receiving the Board's response, the Tribunal granted the claimant benefits for traumatic mental stress. This decision is significant as it expands the types of workplace traumatic mental stress cases that can lead to compensation under the *WSIA*. *Decision No. 483/11I*, 2011 ONWSIAT 1231 (CanLII). See also commentary describing the outcome and impact of the decision; e.g. Heenan Blaikie, WSIAT Expands the Scope of Entitlement for Traumatic Mental Stress, 10 January 2012, www.mondaq.com/canada/x/160258/Employee+Rights/WSIAT+Expands+The+Scope+Of+Entitlement+For+Traumatic+Mental+Stress: retrieved April 18, 2012.

[121] *Plesner v. British Columbia Hydro and Power Authority*, 2009 BCCA 188 (CanLII).

[122] Bill 14, *Workers Compensation Amendment Act, 2011* was introduced in November 2011 and has had first reading in the BC Legislature. It is not clear at this time whether these amendments will pass and become law.

[123] Mental Health Works, "What kinds of accommodations can I ask for?" online: Mental Health Works www.mentalhealthworks.ca/employees/faqs/accommodations/types, retrieved January 16, 2012, Great West Life Centre for Mental Health in the Workplace, "Accommodations that work", online: Great West Life Centre for Mental Health in the Workplace www.gwlcentreformentalhealth.com/display.asp?l1=175&l2=6&d=6 retrieved January 16, 2012.

[124] For a discussion of the human rights considerations related to last chance agreements, see the Ontario Human Rights Commission's publication *Human Rights at Work*, 2008 www.ohrc.on.ca.

[125] Standing Senate Committee on Social Affairs, Science and Technology, *supra* note 6; Government of Ontario, *supra* note 6.

[126] For more information on this topic, see Yona Lunsky & Jennifer Puddicombe, "Dual Diagnosis in Ontario's Specialty (Psychiatric) Hospitals: Qualitative Findings and Recommendations. Phase II Summary Report" (December 2005) online: Centre for Addiction and Mental Health www.camh.net/Care_Treatment/Program_Descriptions/Mental_Health_Programs/Dual_Diagnosis/dual_diagnosis_ontpsyhos_ph2dec05.pdf.

[127] For example, the 2008 Auditor General of Ontario found that funding for addiction treatment services and community-based mental health services was below targets and the levels required to match the demand for services. Office of the Auditor General of Ontario, *2008 Annual Report of the Office of the Auditor General of Ontario* (Toronto: Queen's Printer for Ontario, 2008) online: Office of the Auditor General of Ontario www.auditor.on.ca/en/reports_en/en08/ar_en08.pdf at 185.

[128] Commission on the Future of Health in Canada, *Building on Values: The Future of Health Care in Canada, Final report*, (November 2002) at 178 (Commissioner: Roy J. Romanow); Ministry of Health and Long-term Care, *Every Door is the Right Door: Towards a 10-Year Mental Health and Addictions Strategy, A Discussion Paper* (Toronto: Queen's Printer for Ontario, 2009) at 9.

[129] Public expenditure on mental health was 6.1% of the total public expenditure on health of $91.4 billion. This spending is above the benchmark of 5% set by the Mental Health Economics European Network, but lower than most developed countries. A value below 5% may represent an unfair allocation to mental health (Mental Health Europe, 2004). P. Jacobs *et al.*, "Expenditures on mental health and addictions for Canadian provinces from 2003 and 2004" (2008) 53:5 Can.J.of Psychiatry 33, as cited by Institute of Health Economics, *How Much Should we Spend on Mental Health?* (September 2008) at 25.

[130] Mental Health Commission of Canada, *supra* note 93 at 13.

[131] *Auton (Guardian ad litem of) v. British Columbia (Attorney General)*, [2004] 3 SCR 657 at para. 41.

[132] *Hogan v. Ontario (Ministry of Health & Long-Term Care)*, 2006 HRTO 32 (CanLII); Resource allocation for mental health services is based on multiple factors. Research has suggested that perception of personal responsibility is the single biggest correlate of the values influencing decisions about resource allocation. Perceptions about people's personal responsibility for their own mental health issues may influence funding for mental health services, and could explain why these programs are funded at lower levels than other services. For a review of the literature, see Patrick W. Corrigan and Amy C. Watson, "Factors that Explain how Policy Makers Distribute Resources to Mental Health Services" (2003) 54:4 Psychiatric Services 501.

[133] For more information on anti-stigma initiatives across Canada, see Mental Health Commission of Canada, "Opening Minds" online: Mental Health Commission of Canada www.mentalhealthcommission.ca/English/Pages/OpeningMinds.aspx.

[134] *CRPD*, *supra* note 9, Article 24(2).

[135] *Education Act*, R.S.O. 1990, C. E.2, O. Reg. 181/98 Identification and Placement of Exceptional Pupils, s.17 (1), Ontario Human Rights Commission, *Guidelines on Accessible Education*, (Toronto: Queen's Park Printer, 2004) online: OHRC www.ohrc.on.ca/en/resources/Guides/AccessibleEducation.

[136] Ministry of Education, Policy/Program Memorandum No. 119. online: Ministry of Education www.edu.gov.on.ca/extra/eng/ppm/119.html.

[137] Ontario Ministries of Children and Youth Services, Health and Long-term Care, Education, News release, "Improving Mental Health Supports for Ontario Kids and Families" (22 June 2011); Government of Ontario, *supra* note 6 at 12, 14.

[138] Ontario Works recognizes that relapse may prevent people from completing their treatment goals, and outlines progressive steps to promote treatment compliance. Ultimately, however, lack of attendance at a treatment program may lead to a decision to end or reduce assistance due to non-compliance. Ministry of Community and Social Services, *Ontario Work Policy Directives, 8.4. Addiction Services Initiative (ASI)* (February 2009), online: MCSS www.mcss.gov.on.ca/documents/en/mcss/social/directives/ow/0804.pdf at 4-5.

[139] *CRPD, supra* note 9, Article 25(a)(b)(d)(f).

[140] CAMH stated, "patients with severe mental illness who experience a heart attack are significantly less likely than the general population to receive drug therapies of proven benefit, are less likely to undergo cardiac catheterizations and receive emergency angioplasties or coronary artery bypass graft surgery." J. Newcomer and C. Hennekens, "Severe Mental Illness and Risk of Cardiac Disease" (2007) 298:15 J.A.M.A. 1794. CAMH also cited a study that estimates that 35% of people with serious mental disorders have at least one undiagnosed medical disorder. Bazelon Centre for Mental Health Law, *Get it Together: How to Integrate Physical and Mental Health Care for People with Serious Mental Disorders* (2004). It also noted that the cancer death rate is 65% higher among the mentally ill.. André Picard, "Cancer death rate 65% higher among the mentally ill, *The Globe & Mail* (9 April 2009), online: The Globe & Mail www.theglobeandmail.com/life/article965397.ece.

[141] Several mental health and addiction agencies submitted in 2008 to the Ministry of Health and Long-term Care that the Canadian Triage and Acuity Scale identifies "psychiatric complaints" (with the exception of suicidal ideation/attempts) as a "Level Five category response": the very lowest level. They recommended that the effect on wait times and quality of care be examined and remedied. Addictions Ontario, *et al., Addressing Emergency Department Wait Times and Enhancing Access to Community Mental Health & Addictions Services and Supports*, Submission to the Minister of Health and Long-Term Care (May 2008) at 5; The Canadian Triage and Acuity Scale criteria was revised for mental health complaints; See Michael J. Bullard *et al.*, "Revisions to the Canadian Emergency Department Triage and Acuity Scale (CTAS) Adult Guidelines" (2008) 10:2 C.J.E.M. 136, online: CJEM www.cjem-online.ca/sites/default/files/pg136(3)(1).pdf.

[142] The PPAO told us that this issue arose during the inquest into the death of Ryan Coulter, who according to the PPAO, may not have received medical care while in psychiatric hospital because his physical symptoms were attributed to his psychiatric condition, including multiple addictions.

[143] Select Committee on Mental Health and Addictions, *Navigating the Journey to Wellness: The Comprehensive Mental Health and Addictions Action Plan for Ontarians, Final Report* 2nd Sess., 39th Parliament 59 Elizabeth II (Toronto: Queen's Printer for Ontario, 2010), online: Legislative Assembly of Ontario www.ontla.on.ca/committee-proceedings/committee-reports/files_pdf/Select%20Report%20ENG.pdf, Recommendation 12 at 10.

[144] College of Physicians and Surgeons of Ontario, *Accepting New Patients*, Policy directive #1-09 (April 2009) online: CPSO www.cpso.on.ca/policies/policies/default.aspx?ID=2506 at 2.

[145] *Mental Health Act*, R.S.O. 1990, c.M.7., s. 15.

[146] Before the *CRPD* came into effect, standards and guidelines for caring for and treating people in mental health institutions (called *Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care*) were adopted by the General Assembly (Resolution 46/119 of 17 December 1991). The *CRPD* supersedes these principles.

[147] "Persons with disabilities are often segregated from society in institutions, including prisons, social care centres, orphanages and mental health institutions. They are deprived of their liberty for long periods of time including what may amount to a lifelong experience, either against their will or without their free and informed consent ... Inside these institutions, persons with disabilities are frequently subjected to unspeakable indignities, neglect, severe forms of restraint and seclusion, as well as physical, mental and sexual violence. The lack of reasonable accommodation in detention facilities may increase the risk of exposure to neglect, violence, abuse, torture and ill-treatment." *Interim report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment* UN GAOR 63rd Sess., UN Doc. A/63/175, (2008) at 9 para. 38.

[148] "The Special Rapporteur notes that there can be no therapeutic justification for the prolonged use of restraints, which may amount to torture or ill-treatment ... Within institutions, persons with disabilities are often held in seclusion or solitary confinement as a form of control or medical treatment, although this cannot be justified for therapeutic reasons, or as a form of punishment." Note by the Secretary-General, *ibid.*, paras 55-56.

[149] Note by the Secretary-General, *ibid.*, at 16 para 63.

[150] *CRPD, supra* note 9, Article 14(1)(b).

[151] United Nations High Commissioner for Human Rights and Reports of the Office of the High Commissioner and the Secretary-General, *Thematic Study by the Office of the United Nations High Commissioner for Human Rights on enhancing awareness and understanding of the Convention on the Rights of Persons with Disabilities*, Human Rights Council 10th Sess., UN GAOR Doc No. A/HRC/10/48, (2009) at para 49.

[152] Law Commission of Ontario, *Advancing Equality for Persons with Disabilities Through Law, Policy and Practice: A Draft Framework* (March 2012).

[153] *Thematic Study by the Office of the United Nations High Commissioner for Human Rights on Participation in Political and Public Life by Persons with Disabilities*, UN GAOR Human Rights Council 19th session UN Doc. A/HRC/19/36, 2011 at para 30.

[154] *Ibid.*, at para 68.

[155] It also reserves the right to forgo regular reviews by independent an independent authority, citing its own appeal mechanisms. *CPRD, supra* note 9, Canada's Declaration and Reservation, online: UN Treaty Collection treaties.un.org/pages/ViewDetails.aspx?src=TREATY&mtdsg_no=IV-15&chapter=4&lang=en#EndDec.

[156] *Substitute Decisions Act*, S.O. 1992, c.30; *Health Care Consent Act*, S.O. 1996, c. 2, Sched. A.

[157] *CRPD, supra* note 9, Article 12(3).

[158] Michael Bach & Lana Kerzner, *A New Paradigm for Protecting Autonomy and the Right to Legal Capacity*, (October 2010) online: LCO www.lco-cdo.org; The World Network of Users and Survivors of Psychiatry argues that agencies such as banks, judges or medical personnel that often deal with acts requiring an exercise of legal capacity need to provide some support measures as a form of accommodation. World Network of Users and Survivors of Psychiatry, *supra* note 23 at 17; The Commissioner for Human Rights for the Council of Europe recommends, "[Create] a legal obligation for governmental and local authorities, the judiciary, health care, financial, insurance and other service providers to provide reasonable accommodation to persons with disabilities who wish to

access their services. Reasonable accommodation includes the provision of information in plain language and the acceptance of a support person communicating the will of the individual concerned." Commissioner for Human Rights, Council of Europe, *Who gets to decide? Right to Legal Capacity for Persons with Intellectual and Psychosocial Disabilities* (Strasbourg: 2012) CommDH/IssuePaper(2012)2, online Council of Europe https://wcd.coe.int/ViewDoc.jsp?id=1908555 at Recommendation 9.

[159] Standing Senate Committee on Social Affairs, Science and Technology, *supra* note 6, at 230.

[160] *Fleming v. Reid*, [1991] O.J. No. 1083, 1991 CanLII 2728 (ON CA), paras. 33-34.

[161] A person is capable with respect to a treatment, admission to a care facility or a personal assistance service if they are able to understand the information that is relevant to making a decision about the treatment, admission or personal assistance service, as the case may be, and able to appreciate the reasonably foreseeable consequences of a decision or lack of decision. *Health Care Consent Act*, S.O. 1996, c. 2, Sched. A. s. 4(1).

[162] Dreezer and Dreezer Inc. *Report on the Legislated Review of Community Treatment Orders, Required Under Section 33.9 of the Mental Health Act.* Prepared for the Ontario Ministry of Health and Long-Term Care (December 2005) at 14.

[163] Registered Nurses Association of Ontario, *Promoting Safety: Alternative Approaches to the Use of Restraints* (Toronto: Registered Nurses' Association of Ontario, 2012) online: RNAO www.rnao.org/Storage/88/8224_FINAL_BPG_FOR_WEBSITE.pdf at 19.

[164] The *Patient Restraints Minimization Act, 2001*, S.O. 2001, c. 16, promotes least restraint principles and mandates developing restraint policies in hospitals and other facilities. However, it does not apply in circumstances in which the *Mental Health Act* governs the use of restraints on patients or other persons in psychiatric facilities (see s. 2 (2)).

[165] Nursing homes with a higher proportion of full-time registered nurses (RNs), compared with part-time and contract RNs, have been associated with less frequent use of restraints. Robert Weech-Maldonado, Louise Meret-Hanke, Maria C. Neff & Vince Mor, "Nurse Staffing Patterns and Quality of Care in Nursing Homes" (2004) 29:2 Health Care Man. Rev. 107.

[166] The types of restraint used were: acute control medication, physical restraint, mechanical restraint or seclusion. Canadian Institute for Health Information, *Restraint Use and Other Control Interventions for Mental Health Inpatients in Ontario* (August 2011) online: Canadian Institute for Health Information www.cihi.ca at 1.

[167] Registered Nurses' Association of Ontario, *supra* note 163.

[168] Registered Nurses' Association of Ontario, *supra* note 163 at 39.

[169] Ontario Association of Chiefs of Police, "Resolution 2011-01, Mental Health and Addictions" (June 29, 2011), online: Ontario Association of Chiefs of Police www.oacp.ca/content/resolutions/view_resolution.html?id=132.

[170] Canadian Mental Health Association Ontario Branch, "Justice and Mental Health" online: Canadian Mental Health Association Ontario www.ontario.cmha.ca/justice.asp, retrieved January 31, 2012.

[171] Section 17 of Ontario's *Mental Health Act* gives police officers the authority to bring someone to a medical facility for assessment if the officer has "reasonable and probable grounds" to believe a person has acted in a "disorderly manner" if the person is believed to have a mental disorder that will likely result in bodily harm to himself, another person or serious physical impairment, and the person has threatened or attempted to harm themselves, has behaved violently or caused someone to fear bodily harm, or has shown an inability to care for themselves.

[172] Carys Mills, "Ontario to review how police respond to the mentally ill" *The Globe and Mail* (2 May, 2012) online: The *Globe and Mail* www.theglobeandmail.com/news/national/toronto/ontario-to-review-how-police-respond-to-the-mentally-ill/article2420940/.

[173] The RCMP deployment rate of conducted energy weapons was 49.6% for mental health Incidents, which was significantly higher than it was for non-mental health cases (39.2%). "Mental health incidents resulted in more deployments than did any other incident type ... There was no discernable evidence that mental health cases were any more risky than other incident types." Commission for Public Complaints Against the Royal Canadian Mounted Police. *RCMP Use of the Conducted Energy Weapon (CEW): January 1, 2009 to December 31, 2009* (June 24, 2010); online: Commission for Public Complaints Against the RCMP www.cpc-cpp.gc.ca/prr/rep/sir/cew-ai-10-eng.aspx at 46-47.

[174] Anita Barnes, "Accommodating people with mental health issues and addictions in the tribunal system" (Presentation given to the Society of Ontario Adjudicators and Regulators, 1 June 2011). Online: Society of Ontario Adjudicators and Regulators www.soar.on.ca/docs/Accommodating%20people%20at%20tribunals.pdf.

[175] Howard Sapers, Annual Report of the Office of the Correctional Investigator 2008-2009 (June 29, 2009) online: Office of the Correctional Investigator www.oci-bec.gc.ca/rpt/annrpt/annrpt20082009-eng.aspx#2.1.

[176] Select Committee on Mental Health and Addictions, *supra* note 143 at 13.

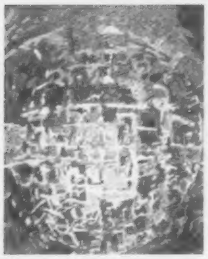
[177] Statistics collected by the Correctional Investigator Canada show that the percentage of African Canadians in the federal corrections system is increasing, from 6.27% of the total number of inmates in 2000-2001, to 8.4% of the total number of inmates in 2010-2011. CSC Corporate Reporting System, as of 2011-2012. Provided to the OHRC by the Office of the Correctional Investigator Canada.

[178] *Concluding observations of the Committee against Torture: Canada (Advance Unedited Version)*, UN Committee Against Torture 48th Sess., UN Docs. CAT/C/SR.1087 and 1088, 2012 at para 19.

[179] Where justice issues relate to a mental health issue or addiction, people may be likely to use administrative tribunals such as the Social Benefits Tribunal, the Consent and Capacity Board, the Landlord and Tenant Board, the HRTO, and the OMB. These tribunals have the ability to and should apply the *Code* in cases that raise human rights issues; *Tranchemontagne v. Director (Disability Support Program)*, [2006] 1 S.C.R. 513 at paras. 23 – 24; this is because the *Code* is fundamental, quasi-constitutional law. It must not only be given expansive meaning, but also offered accessible application.

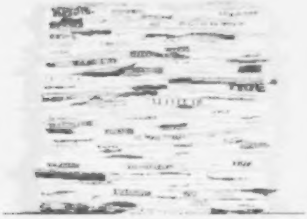
[180] Tess Sheldon & Ivana Petricone, *Access to Administrative Justice for Persons with Disabilities. Addressing the Capacity of Parties before Ontario's Administrative Tribunals; Promoting Autonomy and Preserving Fairness* (Toronto: ARCH, 2009) at ii, iii.

[181] The *Code* protects people from reprisal for making a human-rights related complaint (section 8).



Chris Crewe – Liquid Sunset #1

Chris Crewe is a Toronto-based visual artist, with a studio in the downtown core. Chris' work is influenced by elements of the industrial landscape in Toronto. He is fascinated by the way structures are put together and by how they come apart. In his paintings he breaks things down into their most simple elements and then re-constructs them in different ways. The core theme throughout his work is about expressing impermanent environments which exist when concrete and organic forms interact. His art has been featured in many publications and shown in galleries around Toronto. He frequently contributes his art to charitable organizations to raise money for social change. www.ccrewe.com



Lynda Foston – Utterance of Addiction

Lynda Foston is a Durham-based artist. She specializes in personalized word art applying various mediums; making each piece tell a story or make a statement. Her work supports issues people struggle with such as addiction, mental illness and stereotyping. Lynda is a great advocate for people with disabilities.

Design: ASAP design inc.

Published by the Ontario Human Rights Commission
Province of Ontario, Toronto, Canada
© 2012, Government of Ontario

ISBN: 978-1-4606-0099-3 (Print)
ISBN: 978-1-4606-0100-6 (HTML)
ISBN: 978-1-4606-0101-3 (PDF)

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